dical Library
OCT 2 0 1945

PUBLIC HEALTH NURSING

JULY
1945

■ ADMINISTRATION OF HOME NURSING BY HEALTH DEPARTMENTS

■ PUBLIC HEALTH NURSE IN A SMALL INDUSTRY
MARY JANE NICKERSON

■ FIELD TEACHING
WINIFRED KELLOGG

■ PROBLEMS OF INTEGRATION

■ A BLUEPRINT FOR LAY PARTICIPATION
GRACE N. KIECKHEFER

ALABAMA
Birmingham: Loveman, Joseph & Loeb
ARIZONA
Phoenix: Korrick Dry Goods Co.
Tucson: Jacome's
ARKANSAS
Fort Smith: Boston Store Dry Goods Co.
Little Rock: Ike Kempner and Bros., Inc.
CALIFORNIA
Hollywood: The Broadway-Hollywood
Long Beach: Dobyn's Footwear
Los Angeles: Broadway Dept. Store, Inc.
Oakland: Kahn Dept. Store, Inc.
San Diego: The Marston Co.
San Francisco: Sommer and Kaufmann
COLORADO
Colorado Springs: Vorhes Shoe Co.
Denver: The May Co.
CONNECTICUT
Bridgeport: D. M. Read Co.
Hartford: Sage-Allen and Co., Inc.
DELAWARE
Wilmington: Kennard-Pyle Co.
DISTRICT OF COLUMBIA
Washington: Frank R. Jelleff, Inc.
FLORIDA
Jacksonville: Cohen Bros.
Pensacola: Meyer Shoe Co.
GEORGIA
Atlanta: Rich's, Inc.
Augusta: Saxon-Cullum Co.
Columbus: Miller-Taylor Shoe Co.
Macon: Arnold Shoe Co.

IDAHO
Moscow: David's, Inc.
ILLINOIS
Chicago: Marshall Field and Co.
INDIANA
Indianapolis: Geo. J. Mgrott
South Bend: Robertson Bros. Dept. Store
IOWA
Des Moines: Field Shoe Co.
Dubuque: Walker Bros., Inc.
Sioux City: T. S. Martin Co.
Waterloo: Walker's Shoe Store
KANSAS
Wichita: John Braitsch Shoe Store
Wichita: Jones-O'Neal Shoe Co.
KENTUCKY
Lexington: Baynham Shoe Co.
Louisville: Baynham Shoe Co.
LOUISIANA
New Orleans: Imperial Shoe Store
Shreveport: Phelps Shoe Co., Ltd.
MAINE
Portland: Davis and Cartland Co.
MARYLAND
Baltimore: S. Dalsheimer and Bro.
MASSACHUSETTS
Boston: Wm. Filene's Sons Co.
Springfield: Forbes and Wallace, Inc.
Worcester: Denholm and McKay Co.
MICHIGAN
Detroit: J. L. Hudson Co.
Flint: Rowe's Walk-Over Boot Shop
MINNESOTA
Duluth: Duluth Glass Block Store Co.
Minneapolis: The Dayton Co.
Minneapolis: Home Trade Shoe Store
St. Paul: The Emporium Merc. Co.
MISSISSIPPI
Jackson: R. E. Kennington Co.
MISSOURI
Kansas City: Robinson Shoe Co.
St. Louis: Famous-Barr Co.
NEBRASKA
Omaha: J. L. Brandeis and Sons
NEVADA
Las Vegas: Ronzone's Dept. Store
NEW HAMPSHIRE
Portsmouth: Shaine's
NEW JERSEY
Elizabeth: Ruthal's
Hackensack: Stenchever's
Newark: Hahne and Co.
Passaic: Stenchever's
Paterson: Stenchever's
Trenton: Ruthal's
NEW MEXICO
Albuquerque: Paris Shoe Store
Santa Fe: Pflueger's

There will always be

THE CLINIC SHOE

REG. U. S. PAT. OFF. AND CANADA

for Young Women in White

TO INSURE BEAUTIFUL...COMFORTABLE...HEALTHY FEET

$6.00 to $7.00

In Canada $8.00 to $10.00

Lack of space prevents the listing of all Clinic Dealers

NEW YORK
Brooklyn: Frederick L[illegible]r Co.
Buffalo: Flint a[illegible] Kent
New York: Bloomingdale Bros., Inc.
New York: Stern Brothers
New York: John Wanamaker
Rochester: Wm. Eastwood and Son Co.
Syracuse: Park-Brannock Shoe Co.
Utica: C. Sautter's Sons
NORTH CAROLINA
Durham: R. L. Baldwin Co.
Salisbury: Phil's Family Shoe Store
NORTH DAKOTA
Fargo: The O. J. deLendrecie Co.
Grand Forks: Rand Shoe Co.
OHIO
Akron: The M. O'Neil Co.
Cincinnati: Potter Shoe Co.
Cleveland: The May Co.
Columbus: The F. and R. Lazarus and Co.
Dayton: The Rike-Kumler Co.
Springfield: Nisley Shoe Co.
Toledo: The LaSalle and Koch Co.
Youngstown: The Strauss-Hirshberg Co.
Zanesville: J. E. McHenry Shoe Store
OKLAHOMA
Oklahoma City: Kerr Dry Goods Co.

OREGON
Portland: Meier and Frank Co.
PENNSYLVANIA
Philadelphia: S. Dalsimer and Sons
Philadelphia: Strawbridge and Clothier
Philadelphia: John Wanamaker
Pittsburgh: Kaufmann's
Reading: Manning-Armstrong
Scranton: Lewis and Reilly, Inc.
RHODE ISLAND
Providence: The Outlet Co.
SOUTH CAROLINA
Charleston: Jas. F. Condon and Sons, Inc.
Columbia: Saxon-Cullum Co.
SOUTH DAKOTA
Aberdeen: Webb-Carter Shoe Co.
Sioux Falls: Johnson Shoe Co.
TENNESSEE
Memphis: Walk-Over Shoe Store
Nashville: Baynham Shoe Co.
TEXAS
Austin: E. M. Scarbrough and Sons
Dallas: A. Harris and Co.
Dallas: Sanger Bros.
El Paso: The Popular Dry Goods Co.
Fort Worth: Fair Dept. Store
Fort Worth: W. C. Stripling Co.
Galveston: E. S. Levy Co.
Houston: Krupp and Tuffly, Inc.
San Antonio: The Guarantee Shoe Co.
UTAH
Salt Lake City: Z. C. M. I. Dept. Store
VERMONT
Rutland: Wilson Clothing Co.
VIRGINIA
Newport News: Adams Shoe Store
Norfolk: Hofheimer's, Inc.
Richmond: Miller and Rhoads, Inc.
WASHINGTON
Seattle: Frederick and Nelson
Spokane: Spokane Dry Goods Co.
Tacoma: Rhodes Bros.
WEST VIRGINIA
Charleston: Peoples Store, Inc.
Wheeling: Alexander and Co.
WISCONSIN
Milwaukee: Milwaukee Boston Store, Inc.
WYOMING
Cheyenne: Wasserman's Shoe Store

OUR PLEDGE: CLINICS WILL ALWAYS BE OF THE HIGHEST STANDARD OF QUALITY AND WORKMANSHIP IT IS POSSIBLE TO OBTAIN

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Bedside Nursing Care by Official Agencies

BELIEF that care of the sick in their homes is a public health nursing service needed in every community has been registered by not only the National Organization for Public Health Nursing, but also the American Public Health Association, the Conference of State and Territorial Health Officers, and many other groups and individuals. The new bill, "Social Security Amendments of 1945," introduced in the Senate by Senator Wagner (for himself and Mr. Murray) on May 24 provides for home nursing as part of the "personal health service benefits" to be made available to the public at large. Much more will be heard of this bill in months to come. The fact that such service is still not available in most rural areas and many cities of the United States is merely another indication of the need for expansion of our public health resources.

Under what auspices this service is to be given or how it is to be financed are far less important than that it be provided on a communitywide basis by some manner or means in each community. For obvious practical reasons there is general agreement that care of the sick usually must be provided in rural areas through public funds. Occasional county health departments now expect their public health nurses to take responsibility both for usual program activities and for bedside care as needed.

A considerable number of New England towns as well as some similar communities in other areas have long offered this double service. More recently, health departments in a few larger cities have tried the experiment of furnishing complete public health nursing service including care of the sick. Various difficulties present themselves, however, in such undertakings. Perhaps the most common problem, though at first sight the least to be expected, is the reluctance of many health department nurses to give bedside care. Refresher courses, intensive in-service education, supervision by nurses skilled in this field—all are necessary if this reluctance is to be overcome.

Some health officers still sincerely believe curative service should not have a place in health department practice, while many others know that their resources both in budget and personnel are inadequate for such extension of function at present. Still others agree to this addition without realizing all that is involved. Both conviction and understanding on the part of the health officer are needed if nursing care of the sick as a health department service is to be satisfactory.

Then there is the question found in many areas of the legality of accepting fees by health departments. This can be ironed out, as can questions concerning eligibility. In the Report of the Health Program Conference, "Principles of a Nation-Wide Health Program,"* appears a statement which deserves careful consideration. "There is at present a tendency to develop a double system of medical care: (1) a poor-man's system supported by taxation . . . (2) an insurance system for employed persons. . . . Medical efficiency and economy and general social considerations are against a double and in favor of a unified system." Although some people cannot pay, all, according to the report, should have access to the same

*Principles of a Nation-Wide Health Program. Published with cooperation of the Committee on Research in Medical Economics, 1790 Broadway, New York 19, New York, November 1944.

medical resources and under the same conditions.

Finally, there is the necessity to preserve the citizen interest in this public health nursing service which has been developed and maintained under voluntary auspices when it is taken over and administered by an official agency. This important asset might easily be lost unless some way is found of continuing citizen participation through formation of citizens committees for the health department as a whole, or at least for the nursing service.

In spite of the obstacles both within and without to health departments' undertaking of bedside care, here and there official agencies are developing this type of service. In order to help them get off to a good start, the NOPHN Committee on Nursing Administration has attempted to define conditions required for satisfactory nursing care of the sick services in health departments. Their statement appears in this issue of the Magazine (page 339).

It is of special importance now when plans to provide medical care for all the people are under active consideration that public health nursing care of the sick should become widely available. Will tax funds ever be sufficient to provide all the part-time nursing service that would be useful in a community? Is it important that compulsory prepayment insurance plans include visiting nurse service whether given through voluntary agencies or health departments? These are some of the questions that must be decided.

PUBLIC HEALTH NURSING would like comments from its readers on this important subject and on the " . . . conditions fundamental to the best development of community nursing services for the sick under health department auspices" as listed by the Committee on Nursing Administration.

Nursing Council to Carry on with Urgent Problems

FULL determination to carry through cooperatively the war nursing jobs undertaken since Pearl Harbor was voted by the National Nursing Council for War Service following a post-VE checkup at its corporation meeting in New York, May 18.

"Victory in Europe challenges any organization slated, as is the National Nursing Council for War Service, to terminate its activities six months after the war is ended, to pause long enough to evaluate its different projects, to see what efforts might be tapered off, and what should take on new emphases," said Mrs. Elmira B. Wickenden, executive secretary, in her report.

Needs of the armed services should determine any future responsibility for military recruitment on the part of the Council, she said. Civilian shortages, on the other hand, will continue until nurses now in military services are being demobilized in considerable numbers she declared. The Council has recently accelerated its efforts toward better distribution and utilization of the nurses available to the home front.

"Since these shortages are closely related to such long-term problems as wages and working conditions, administrative deficiencies, transportation and the like, any adequate facing of problems must go beyond wartime makeshifts," Mrs. Wickenden said, urging that the inter-agency group now working on civilian nurse mobilization transmit to the National Nursing Planning Committee any ideas growing out of its experience that promise aid in solving the long-term problems.

The Planning Committee has developed, with the cooperation of all nursing organizations represented in the Council, a tentative plan for nationwide action in nursing. (See page 376.) Its speedy completion and release by the Committee was recommended because of the state and local groups, some already involved in transitional problems, which are looking for national guidance.

Mrs. Wickenden described the rapidly expanding activities of the Negro unit,

(Continued on page 370)

Five Years of Wartime Health Planning

By LEN CHALONER

TO BRING out an immediate working program of health for the inhabitants of an island fortress in a war that would last for an indeterminable period in largely unpredictable conditions of warfare was the task which faced the authorities in Britain in 1939.

There was almost certainly going to be heavy bombing and no one could be sure just how soon it would begin. There might also be attempted invasion, though this did not loom close until a year later. And experience in World War I had shown how vital a part nutrition would play in the struggle for victory.

From the outset all three problems were closely linked.

If there was to be bombing there must not only be evacuation for as many mothers and young children as possible, but there must be shelter arrangements for the public left in the target areas. Yet shelter accommodation on a large scale immediately suggested the dangers of communicable diseases, which at all costs must be prevented. To combat such possibilities there must be prompt measures to secure proper sanitation in the big shelters; sleeping accommodation in as many as possible, including domestic ones; welfare supervision by trained personnel in addition to first aid provision. And beyond all, steps must be taken to educate the public to their share of responsibility and an understanding of the measures essential for their own safety and well-being.

Mrs. Chaloner, a well known British journalist and founder of the British Parents' *magazine, has made a special study of health matters and child welfare. She is a former member of the Committee of the Nursery Schools Association of Britain.*

This detailed program had to be put in hand in addition to the military needs of civil defense organization—A.R.P., fire fighting services, rescue workers, demolition squads and so on. Few onlookers at the time realized the tremendous energy and planning that the new organizations made on those responsible for them.

The need for a dispersal policy, not only for military reasons but for health ones, became increasingly clear in the early months of the war. If some of the public could be given reasonable shelter in their own homes, not only would casualties be reduced as compared with the numbers involved if large shelters were damaged, but the chance of epidemics and communicable diseases spreading would also be reduced. Experiments led to two excellent designs for home shelters—the Anderson in steel, put up in garden or back yard, and the Morrison table for two-story houses, since it would bear the weight even if the roof of the house caved in. But in spite of the help that these very efficient shelters afforded, many people liked outside company in times of danger, and the utmost vigilance was needed in view of the possibilities, in public shelters, of the spreading on a big scale of diseases like tuberculosis, diphtheria or even venereal diseases.

Propaganda must teach people the dangers of infection even from the common cold. The authorities were only too mindful of the terrible 'flu epidemic in Britain of 1918-19.

"Coughs and sneezes spread diseases!" proclaimed Ministry of Health posters in gay colors on the walls of buses, shelters, and other public places. Indeed, posters, plain and illustrated, sprang up like mushrooms, dealing with all sorts of topics, reminding and explaining and edu-

School children generally were fed a substantial noon meal as well as a mid-morning glass of milk

cating the public in the best ways to meet the strange new world in which they found themselves. Many independent social welfare associations cooperated with the central authorities in their work —the Central Council for Health Education with its affiliated groups, the Provisional Council for Mental Health, and others concerned with the health of mothers and babies all over the country.

In the meantime, the evacuation of mothers and babies had helped the towns from the shelter point of view but was now bringing new problems and congestion to the country schools. Propaganda began to permeate the most rural districts and the Minister of Food added his message to that of the Minister of Health.

Local authorities and schools were stirred up by campaigns to encourage parents to have their children immunized against diphtheria. And posters and pamphlets were used as signposts to the immunization stations in many districts.

BUT EVEN from the word "war," Britain's Minister of Food had started his great campaign to assure the vital foods to rich and poor alike all over the country at controlled prices, and to give priority in milk and dairy foods to mothers-to-be, mothers with new babies, and babies and young children themselves. These must all have an adequate supply of milk cheaply—in fact free in necessitous cases—and priority for shell eggs when these were available. Since butter supplies would be limited, vitamins must be added to all margarine; there should be no repetition of that 'flu epidemic if the Minister of Food could do anything about it! Cod liver oil and orange juice for mothers and babies must be placed on the same plane as milk.

It was equally important that the mothers themselves should understand the value of such nutrition. Posters, newspaper and magazine advertisements, and broadcasting daily "On the Kitchen Front" reinforced the Minister's messages in every type of reminder and suggestion. Popular lectures, demonstration kitchens and advice kiosks followed up the campaign, and again independent organizations like the women's institutes gave wholehearted support.

Side by side with this work of the Minister of Food and in close cooperation, the Minister of Health decided that the mother-to-be and the young mother could not be permitted to remain in London or other target areas for the time around the confinement just because they might have no relatives in safer districts to whom they could go.

A complete maternity service for them was therefore set up, dovetailing with the peacetime infant welfare centers where antepartum clinics had already become familiar to the public. The mother-to-be was linked up, via these, with the emergency maternity homes which the Ministry of Health set up all over the country, often in very beautiful surroundings, these homes in turn working in touch with the specialists of the district for emergency purposes. The mother was also enabled to stay in billets or specially set up hostels near the emergency home for four weeks before her baby was due, so that the journey should not be made too late in her pregnancy. Over 135,000 babies were born in these emergency maternity homes up to the end of July 1944. It is a testimony to these Ministerial provisions that though the birth rate in Britain in 1943 was the highest since 1928, the stillbirths and neonatal mortality was the lowest on record. New low records for infant mortality and deaths of children between one and ten years were also established in this fifth year of war.

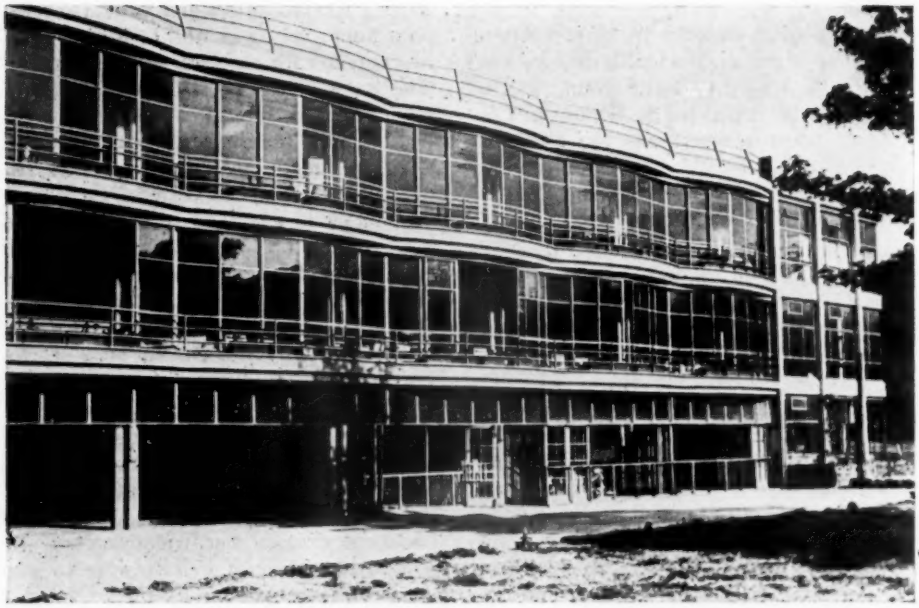
School-age children constituted yet another claim on the Minister of Food's vast Mother Hubbard's cupboard which must never be allowed to become bare. The policy of special milk allowance for schools was followed up by the policy of school meals—a mid-day dinner that ensured a menu of meat and vegetables and pudding to the growing youngsters whether they lived at home or in billets. If it helped the housewives, it helped the children enormously. They gained appreciably in weight, and the teachers found that the added well-being increased their general intelligence.

All this special attention to the health of children was in addition to the ordinary rationing, to the organization of British Restaurants which provided meals on a nonprofit basis, and to the provision of canteens for workers in the factories. The work of the Minister was not made easier by the fact that all food had to be stored on the dispersal policy that applied to the public itself, for with the dangers of heavy air attacks there must be no risk in any part of the country of large food stores becoming wrecked. In turn, dispersal demanded careful organization of transport, to ensure the regular delivery of supplies both in normal conditions and in emergencies such as followed the severe air attacks on Coventry, Plymouth, and other cities.

But where were all the perishable foods to come from that the doctors urged were so vital? However courageous Britain's merchant seamen, however generous in their cooperation her friends across the sea, if the people of Britain were to have the protective greenstuffs they needed, a great deal more than ever before had to be grown by themselves.

Out came the immortal slogan, "Dig for Victory," while suggestion and exhortation, and just "how to do it" followed in poster, radio and allied campaigns. Allotments spread like a patterned carpet over every available strip of open ground. Cabbages soon grew in the bombed-out areas of London, and back gardens everywhere were filled with market garden produce. Lawns were devoted to chickens or dug and planted, and housewives took to preserving and bottling, not only home produce but hedgerow food like rose hips and brambles. When women got together anywhere they talked recipes!

ALL THROUGH the five years the panorama has been constantly changing, and constantly calling for new effort and new measures as the war moved on. One could detail hundreds more aspects of the closely interlocked program. On the side of mental health there was increased provision of child guidance centers to benefit the scattered child population. There were play centers for children to counter the desolation of bombed districts, and clubs to



Health centers like this one at Peckham, a London suburb, are envisioned for all of postwar England

prevent loneliness for the evacuated mothers. Tremendous help was also given to the public by the Women's Voluntary Services and the Citizen's Advice Bureau, voluntary bodies of informed women working in close touch with Central authority—distributing food and clothing to those bombed out, and helping the ordinary citizen in his problems of housing changes, evacuation, or the understanding of various wartime regulations.

Since 1942 there has been a vigorous campaign and new legislation to combat the increase in venereal diseases which always accompanies war. Already by 1943 this incidence had been slowed down, and the latest returns show that people are ready to avail themselves of the treatment centers if they are even in doubt about their condition. Many who submitted themselves were found to be free of infection.

There has also been a campaign, supported by mass radiography, to secure early detection of tuberculosis. This has been backed up by a financial scheme to help those who need treatment to undertake it without anxiety about their dependents during this time. While the mortality figures are encouraging, this disease is one which will need steady combating even after the cessation of hostilities.

But year by year there has been a quiet but steady harvesting of the fruits of all this work that has been put into the health campaign. Britain has had no vast epidemics at any time during the whole five years of war; there have been fewer admissions to mental hospitals; the birth rate is the highest for 15 years and the nutritional state of the population is in some respects even better than it was in peacetime. That is not a bad bill of health to bring forward as a start to the greatest job the world has ever attempted —the building of a peace that shall banish want, disease, ignorance, squalor and unemployment—upon which the Allied Nations are preparing to embark together.

Administration of Home Nursing Care of the Sick by Health Departments

THAT home nursing care of the sick is considered an essential community service from the public health point of view is attested by resolutions passed by the Conference of North American State and Territorial Health Officers in 1942 and by the American Public Health Association in the same year endorsing the principle that this type of service should be an integral part of community health programs.

In the report of a survey of needs and resources for nursing care of the sick in 16 communities published by the NOPHN in 1943,* the Committee on Nursing Administration, sponsor of the survey, made the following recommendation pertinent to health department administration:

> Whenever a well organized public health agency such as a department of health already exists, the community-wide general public health nursing service, including care of the sick, should become part of such an agency. When there is no such competent agency, the community-wide nursing service must probably be developed separately through a strong public health nursing committee which is truly representative of the community.

There are still many communities in the United States, urban as well as rural, which lack an organized resource for part-time home nursing care of the sick by public health nurses. As a matter of fact the last census of public health nursing agencies taken by the National Organization for Public Health Nursing in 1941 showed that 17 percent of cities with 50,000 population and more, 65 percent with 25,000 to 50,000, and 66 percent with 10,000 to 25,000 lacked such a resource.** When this service exists, it is still in the large majority of communities administered by a voluntary agency such as a visiting nurse association.

Although community patterns will undoubtedly continue to vary as to the number and kinds of agencies administering public health nursing, it is likely that health departments will become more, rather than less, involved in responsibility for home nursing as governmental health and medical care plans of various types and degrees of comprehensiveness materialize.

For that reason, the Committee on Nursing Administration considers it timely to review the organizational and administrative conditions fundamental to the best development of community nursing services for the sick under health department auspices. These are as follows:

1. If a complete public health nursing service including care of the sick is administered by a health department, provision should be made for a citizens' committee representing consumers and potential consumers of nursing as well as organizations and groups in any way concerned with providing this service. Functions of such a committee would include:

> Advice in regard to policies governing the administration of a broad inclusive community nursing service.
>
> Interpretation to administrators and executive directors of the service of the needs of the community from the consumer-public point of view.
>
> Help in informing the public in regard to purposes, scope, use, and availability of public health nursing services for care of the sick as well as for prevention of illness and health guidance.

*Hilbert, Hortense and Bellos, Sybil. Public Health Nursing Care of the Sick—A Survey of the Needs and Resources for Nursing Care of the Sick in Their Homes in 16 Communities. NOPHN, 1943.

**From unpublished report of data from NOPHN 1941 Census of Public Health Nursing Agencies.

If the citizens' committee functions in relation to the health department as a whole, which is highly desirable, a subcommittee is advisable to give particular attention to the nursing program.

2. Public health nursing can attain its objective, that is, giving home nursing care to the sick, only through cooperation with the private medical practitioners of the community. In addition to the medical personnel employed by the health department and the medical members of the board of health, it is important that provision be made for a medical advisory committee representative of practicing physicians to assist in establishing the service and its general policies.

Since nursing care of the sick in their homes creates relationships with the private medical practitioner which are somewhat different in nature from those involved in the usual health department services, the medical policies under which this service is administered need to be clearly defined at the outset. Other functions of a medical advisory committee to the nursing service might include:

Approval of "standing orders" for certain types of nursing service.

Interpretation of the community nursing service to medical groups in the community.*

3. If nursing care of the sick in their homes is administered as part of the nursing program of a health department, it should be offered as a community service for all age groups and types of sickness, for those who can as well as those who cannot pay all or part of the cost.

All persons requiring this service should be able to secure it from a common source. Differentiations according to economic circumstances whereby those unable to pay receive care from one type of agency and those able to pay part or all of the cost from another, should for obvious social reasons be avoided.

4. It is probable that many additional health departments will, within the next few years, include care of the sick service. Pending a possible time when public funds are available to provide care of the sick service to the total population, health departments should be in a position to accept payment from individuals and organizations* for the full or partial cost of nursing service and to act as a depository for voluntary funds, such as may be received from community chests and other non-governmental resources. Fees thus collected should be returned to the operating fund of the nursing service to be utilized for improvement and expansion of this service.

Legal prohibitions against accepting fees for services rendered, or from entering into agreements with other organizations for such services and for assuming trusteeship for non-tax funds, are among the reasons given by health departments for not administering complete community nursing services including care of the sick. In this connection it is of interest to learn that only 21 of the total sample of 192 city and county health departments included in the 1944 NOPHN Yearly Review stated that there were laws which prevented them from accepting fees from individuals for nursing care. Five, on the other hand, reported laws enabling them to accept fees for this kind of service. As a matter of fact, fees are quite generally accepted by health departments for various types of licenses.

Home nursing care of the sick in their homes should be definitely offered as such, not for demonstration only and merely incidental to other services of the health department. Planned public information and interpretation should be directed to the community regarding the availability and use of this service.

5. Only health departments under direction of well qualified health officers** and having a well organized public health nursing unit, staffed with a sufficient number of well qualified nursing person-

*National Organization for Public Health Nursing. Board Members' Manual. The Macmillan Company, New York, 1938, second edition revised.

*Life insurance companies; industries; health insurance plans; employee organizations; boards of education; public assistance agencies; and others.

**American Public Health Association, Committee on Professional Education. "Educational Qualifications of Health Officers." *American Journal of Public Health*, December 1939.

nel,* are ready to take on the responsibility of operating a comprehensive community nursing service including home care of the sick.

6. A ratio of one nurse at staff level to approximately 2,500 of the general population is required for a complete community nursing service including home care of the sick, rather than the minimum standard of one to 5,000** commonly advocated for health department purposes.

If a health department offers home nursing care to the various age and income groups of the community for noncommunicable and communicable illness, the number of persons admitted to service will increase. Also, bedside nursing of the sick and maternity patients requires more time per unit of service than other public health nursing services traditionally offered by health departments.

Graduate nurses not having public health nursing training and auxiliary workers such as practical nurses and nurse's aides should also be considered for certain kinds of service under public health nursing supervision. This latter group of workers would be included in determining the ratio of one nurse to 2,500 population. Studies are underway to ascertain how many may safely be substituted for qualified public health nurses.

7. Nursing supervisors should be provided in the ratio of one for 8 or 10 staff nurses including students, and experience in home nursing care should be included in their qualifications wherever possible.

8. Intensive in-service training in home care of the sick procedures and/or "internships" in agencies administering this care are needed for nursing personnel not previously having had supervised experience of this kind in health departments which contemplate adding bedside nursing to their general program.

9. Well qualified public health nursing personnel is more readily attracted and held where there are merit systems of personnel administration which provide qualification requirements for each class of position; adequate salary and definite ranges with a stated minimum and maximum, and specified rates and intervals of increase for satisfactory work; promotion possibilities, retirement, and other personnel policies and practices that contribute to good performance.

10. Careful planning is needed in respect to each general public health nurse's district, and her case and daily work load, so that the demands upon her can be met from day to day in order of their relative importance.

11. Adequate equipment, including bags, nursing supplies, aprons, et cetera, is necessary for giving part-time nursing care to the sick with the greatest degree of safety to the worker and the family. Equipment of this kind is ordinarily not provided for the usual health department nursing services. Adequate transportation facilities should also be provided.

Information about health departments administering nursing care of the sick was recently secured through the NOPHN 1944 Yearly Review, which included a sample of 96 city health departments among a total of 483 such services; and of 98 county health departments among a total of 1,258 county services. In response to the question whether care of the sick is provided, 18 city and 20 county health departments replied in the affirmative. However, this information does not disclose whether this is provided as a planned community service for all who need it or for demonstration only and as an accompaniment to the usual health department program.

It must be added that 81 health departments, besides the 38 just mentioned, reported giving some nursing care in emergencies or for demonstration only.

Reports of amounts of payment received for nursing care of the sick in 1943 by the health departments in the sample are indicative of the extent to which it is offered as a planned community service for all ages and income groups. Only 11 of the 192 departments of health

*"Recommended Qualifications for Public Health Nursing Personnel, 1940-1945." PUBLIC HEALTH NURSING, January 1942.

**American Public Health Association. "Units of Local Health Service for All the States." *American Journal of Public Health*, April 1943.

AMOUNT IN FEES RECEIVED IN 1943 FOR NURSING CARE OF THE SICK[1]

Type of health department	Population served 1941	Total nurses employed March 1, 1944	Dollars received in payment 1943	Cents per capita
Municipal Health Department				
1. Kendallville, Ind.	5,431	1	$ 2	0.04
2. Westfield, Mass.	18,793	2	492	2.6
3. La Salle, Ill.	26,500	7	355	1.3
4. Bloomington, Ill.	32,869	6	25	0.07
5. Greenwich, Conn.	35,509	11	772	2.2
6. La Crosse, Wis.	42,707	6	539	1.3
7. Paterson, N. J.	139,656	14	3,156	2.3
County Health Department				
8. Wexford Co., Mich.	17,976	3	37	0.2
9. Monroe Co., Mich.	58,620	7	155	0.3
10. Charleston Co., S. C.	121,105	22	168	0.1
11. Allen Co., Ind.	36,674	4	860	2.3

[1] Source: NOPHN 1944 Yearly Review.

reporting received any payment for this type of nursing care. The type of health department, population of the community, number of public health nurses on the staff, and amounts received in payment in 1943, are given below for each of these 11 communities:

No attempt was made to determine whether the amount of nursing care of the sick given in the 11 communities was adequate.

An organized community resource for home nursing care of the sick is a necessary part of the present-day and postwar public health nursing program, whether administered directly by the health department or separately organized but operating in close cooperation with it. More and more health departments, especially in the less thickly populated areas, are seeing the need for complete public health nursing programs in their communities, including bedside care. As time goes on they will undoubtedly become involved as administrative agencies for these services. The conditions listed above are believed to be basic to effective administration of nursing care of the sick in their homes by public health nurses in health departments.

Approved by the Committee on Nursing Administration of the National Organization for Public Health Nursing.

THE Government needs and asks its citizens in this fourth year of the war against Japan to:

1. Plan to spend your vacation at home and leave railroads free for increasing furlough travel and redeployment of men to the Pacific.

2. Join the Cadet Nurse Corps and help meet your country's wartime nursing needs. Sixty thousand high school graduates between 17 and 35 are needed. Ask your local hospital about this free training.

3. Salvage waste paper scraps as well as newspapers and magazines. The paper shortage remains critical.

4. Serve in your community as a price panel assistant. Volunteers are urgently needed in the job of holding prices down and preventing inflation. See your local rationing board.

5. Make sure of the biggest possible harvest from your Victory garden, and store and can for your family's needs. Civilian supplies of canned vegetables will be lower next winter.

The Public Health Nurse in Small Industry

By MARY JANE NICKERSON, R.N.

A TALL thin man has come up to the plant first-aid room, coughing and breathing heavily. His face is fringed with a white cottony substance, his clothes whitened by it, and his brown hair greyed. He looks as though the ashes of Paracutin had sifted down upon him. But those are no ashes, nor is it the same cloud-like wool that clings to so many workers in this felt mill. He has been covering felt with latex, which is blown onto it in such minute particles that it forms a heavy, white, and choking suspension in the air. He just started this job. It's a new process, initiated by recent wartime demands. The room is provided with a small blower to aid ventilation. He has been given a mask consisting of a noseguard and goggles, which he does wear, but pushed high on his forehead. "I can't work with that on. The goggles cloud and I can't see. Besides the latex comes in around the edges."

Thus another case has come to the nurse's attention. She asked the man about his cough and found that he had had "bronchitis" for years, but that this new work accentuated it and also gave him chest pain. She inquired about his family history, and added to his medical record the following facts: his mother died of "hasty consumption" when he was a baby; his wife died of pulmonary tuberculosis during the last war, leaving an infant son who has spent much of his life in a sanatorium. Now an adult, he was discharged several years ago, but according to his father had had no subsequent chest x-rays. The father himself had not been checked, nor had he been aware of his need for it, despite his constant cough. Happily, the attending physician at the felt mill found no sign of chest disease and a chest film in the patient's community center corroborated his findings. The nurse discussed tuberculosis prevention and follow-up with the patient, who promptly saw that his son visited their private physician. Meanwhile the nurse telephoned the doctor and explained the situation to him.

About the patient's immediate distress: the nurse and doctor at the mill went to his department and watched him work. The doctor advised immediate installation of a powerful blower, a suggestion which the management lost no time in carrying out. They reinforced and padded the mask edges with cotton and felt so there could be no leakage, and the unnecessary goggle glass-pieces were removed. Whenever it became clogged with latex the nose filter on the mask was removed and cleaned. Periodic physical checkup and x-ray of the patient's chest was planned. The patient was encouraged to report any respiratory discomfort to the nurse.

The nurse's presence in the felt mill was purely experimental at this time. She was and is the staff nurse of our Greenwich (Connecticut) Town Nursing Service assigned to the area in the town of which the felt mill is the center. Here the majority of the mill workers are first and second generation Polish, who came to this country to work in the mill and there have stayed. Their children attend the modern and attractive brick school which stands next to the mill. Many of them live in houses owned by the mill. They feel a deep interest in and loyalty to this industry which has provided a livelihood for them and their parents before them.

Mrs. Nickerson until recently was a staff nurse with the Town Nursing Service, Greenwich, Connecticut. She has a B.A. degree from Swarthmore, an M.N. from the Yale School of Nursing.

The nurse's work among these people until February 1944 followed the lines of a generalized public health nursing program. She visited homes to give bedside nursing care, teach the care of newborn infants, follow up tuberculosis cases and their families. Families who could not afford private medical care brought their babies and preschoolers to her child health clinic. Each day the nurse spent an hour or more in the school, assisting the school doctor, following through on his suggestions, and checking on the bevy of little ailments of children sent in by the teachers. Later in the day she went to the youngsters' homes to discuss their health with their parents. Too often she would find that both parents worked out all day, many of them at the mill. The same difficulty would arise in visiting tuberculosis contacts. And then there was always the problem of talking with the father, in cases where countless endeavors to teach a mother or to get her children to the hospital clinic had been fruitless. Plainly there was a gap in this community health program, of which our director at Town Nursing Service was well aware and which she soon took steps to close. Would not the felt mill profit by a nursing service similar to that given in the school?

The advisory committee of the Town Nursing Service arranged a conference with the manager of the felt mill. They found him eager to begin their proposed experiment of having a public health nurse serve as part-time industrial nurse. Like other progressive managers in industry, he understood the value of a health program with a nurse in daily attendance. However, well aware of the wartime nurse shortage, he had hesitated to employ a full-time nurse in an industry employing less than 400 workers. So it was decided that for a trial period of three months the Town Nursing Service would send the staff nurse who handled the local area into the mill for an hour every morning, a service for which the mill would pay $1.50 an hour.

The typical reaction of the layman to this plan would be, "Well, what good is it to have a nurse for just one hour out of the 24 working hours a day at the mill? Why, she'd *never* be there when she was needed for first aid!" But handling first-aid cases was to be the least of her duties. True, she would treat all those who did come to her during her hour, but her functions included the following:

Individual conferences with employees regarding their own or their family's health or social problems, with referral to the proper town agency as indicated.

Setting up of health records for all employees.

Assistance to the doctor with preplacement physical examinations. (The doctor visits once weekly).

Assistance to the employees in securing correction of defects found in the preplacement physical examinations, by referral to available community, state, or insurance company resources.

Health education by individual or group conferences, also by available posters and pamphlets.

Home visits to the employees living within the township, by the staff nurse for the given area, for illness or health problems.

Participation in the safety program, with frequent tours of the mill to ascertain safety or health measures needed. This included the small restaurant sponsored by the felt mill.

First aid and subsequent nursing care under the direction of the industrial physician.

Supervision of first aid was given by specified employees with first-aid training. (The nurse is not to be on call during the day for plant emergencies. Such cases would be referred directly to the doctor.)

The great day arrived! Our nurse was escorted to the medical room, her new office, by the personnel manager, after a tour of the mill with an explanation of its workings and workers. Few nurses, starting on such a venture, are met with such a well equipped, shining, and spacious first-aid room. To perfect the setting, there was even a waterfall, a young Niagara, roaring in full view a stone's throw from the windows.

Until now the medical program of the mill had consisted of first aid and preplacement physical examinations. First aid was administered by employees who had taken the Red Cross First-Aid Course. Treatment was given at the discretion of the individual first aider, and depended upon his preference of what he found in the medicine cabinet. He recorded his case in a record book which had four column headings: (1) name (2) date (3)

injury (4) first-aid worker. Another first-aid room in another building provided more complete record of cases. Here were noted the hour and the cause of the injury in some detail. The preplacement physical examinations were done at the mill by the plant physician. The examination included a general checkup of heart, lungs, et cetera, and, in addition, blood pressure. Results were recorded on the back of the individual's employment card, kept in the personnel manager's files.

THE felt mill's awareness of the need for written records of all first-aid cases was a wise step in the right direction. However, we felt these records could be far more valuable if they offered more detail, so new column headings were added in the first-aid record book. Most important was additional space for details of the treatment given. Another new column was to be checked if the patient was sent to the doctor or the hospital. Two more columns provided space to record the time and the department of the accident's occurrence, and a third wide column was set aside for details of the cause of the injury. These three columns would be invaluable in the later studies we planned for determining need for new safety measures. And finally, the first aiders were asked to record very specifically the nature and location of the injury as a protection against false claims months or even years afterward.

Revision and standardization of treatments was our next first-aid objective. We discussed the matter with the doctor and submitted to him a tentative list of treatments. The approved orders were then typed and the copies were signed by him. One copy was taped conspicuously on the cover of the first-aid record book, a prominent place where no first aider could fail to see it. Another copy was placed in our files at Town Nursing Service and a third was given to the doctor. Further copies were made to be given out to the first aiders.

The names and departments of the first aiders were confirmed and posted on the door of the medical room, and it was made certain that there were two men available on each of the three shifts. Thus, when an employee came to the room and found it locked there was little delay in summoning the proper person to treat him.

Much of our nurse's time at first was devoted to talking with the first aiders. She called each one in for a conference, went over all the orders, stressing the fact that these orders were the *only* ones to be followed, and demonstrated treatments where necessary. She requested that all cases which might require follow-up be referred to her the following morning. She also discussed signs and symptoms which merited investigation by a doctor, so that the first aiders could be on the alert for them and could urge employees to discuss them with her.

Since all eye cases are sent to an eye specialist, our nurse had a conference with him about first aid for eyes. Contrary to the customary treatment at the felt mill of dropping castor oil in the eye before sending the patient to him, the specialist vehemently requested that oil never be used since it delays the action of his local anesthesia and requires much of his time in removing the oil before he can treat the eye. To the nurse he also demonstrated his technique for irrigating an eye and for removing a superficial foreign body. These procedures were in turn demonstrated to the first aiders.

FOR the health of the patients, to say nothing of ultimate rewards in the felt mill's production rate, we decided that the physical examination program could be expanded considerably. New cards were printed at the request of the plant physician specifically for the physical examination findings. These were to be kept in a locked file in the medical department, rather than downstairs in the personnel office. Added to the original headings were: height, weight, vision (Snellen chart), and Wassermann test. Whenever indicated the doctor referred patients to their local health center for a chest x-ray.

At the same time that each new employee's physical examination card was

started, our nurse also opened a nursing record for him. For this we used the familiar NOPHN General Health Service Record.* The face sheet gives ample space for personal and family health history which the nurse secures in a short conference with the employee, and the continuation sheets can be used for recording all subsequent visits to the first-aid room. For correlation with Town Nursing Service's family folders, we checked employees' names against our main office files. And whenever available, additional family history or problems were written up on the nursing record for the file at the felt mill.

The results of the physical examinations provided a springboard for initial contacts between the nurse and employees who frequently were suspicious and apprehensive. Many of these people had never before had a physical examination. Their families called a doctor only after home remedies had failed. These old Polish families regarded the medical profession with distrust. So often a doctor would necessarily be unable to pull the victim's one foot out of the grave!

The nursing record file was augmented from here by endless referral and copying from the personnel cards of old employees. In a matter of months our files were complete and when confronted with an unfamiliar face we could readily look up the man's address, age, nationality, marital status, occupation and hours, and maybe even get his complete family background from our Town Nursing Service file. We could follow up long-ignored defects, found in preplacement examinations months past, as well as the defects of the newly examined. Soon a long list of prospective individual conferences was drawn up and little by little the employees were called in. Commonest ailments were bad teeth, flat feet, and diseased tonsils. Attention could also be called to epidermatophytosis, poor vision, varicose veins, obesity, heart murmur, hernia, hypertension, and poor hearing due to ear wax. Our Town Nursing Service folders revealed some families with tuberculosis, rheumatic fever, and other conditions meriting frequent checkup.

Of course, no attempt was made by the nurse to treat the defects. Her role was to explain their significance to the employees, ferret out additional signs and symptoms, and convince the employees of their need to see their own doctors or dentists. We found interesting ramifications to even such a homely condition as "Cerumen, left canal." In one case conversation led from ears to headaches and general tiredness, thence to feet. This man told of his difficulty in standing for long periods due to his clubfeet which had undergone many operations and now required special shoes which he could not afford. We promptly referred his case to the Connecticut State Aid for Crippled Children, which in spite of its name handled such need for rehabilitation. That agency sent him to an orthopedic specialist and special shoes were provided at no cost to him.

FREQUENTLY 16-year-olds came in for preplacement examinations and we could follow through on defects found years ago when they were examined by the grammar school doctors. Since our Town Nursing Service has handled all public school nursing in the township, our family records, which are correlated with the school records, could disgorge much interesting material on these youngsters, whether they attended the school in this district or any of the 11 other schools we covered.

Eighteen-year-old Pete was typical. We had known him and his dozen brothers and sisters from birth. We had taught their mother infant care, had watched her children through their preschool days in our child health clinics. And then we spent years of tussling with the tooth and tonsil problem in grammar school, only to have some of the same defects staring at us from their high school health records. The girls had responded fairly well to our clinic referrals, but not so the hardening youths! Sissy stuff! They became a classic problem, known to most of our staff. Pete came to draft age, eager to get into the fight. Confidently he displayed his

*General Health Service Record, National Organization for Public Health Nursing 72. Mead and Wheeler, Chicago, Illinois, 1940.

toughening muscles to the Army doctor. A few days later, refused by the Army, he applied for work at the mill, dejected, and gratifyingly responsive to our nurse's suggestion that he visit the local throat and dental clinics.

We did not allow the first-aid and health follow-up to consume all our nursing time at the felt mill. There were departmental hazards and problems which were revealed by the first-aid book, frequent cuts and scratches in one department, steam burns in another. And most strikingly in need of investigation were the many acid dermatitis cases from the hot, steamy fulling department.

The workers in the fulling department have the not too pleasing task of handling and hauling massive sheets of rough, acid-soaked felt. To protect their hands they wear rubber gloves with gauntlets halfway up to their forearms, while large rubber aprons and boots protect the rest of their bodies and clothes. With the advent of warm weather, many of them develop a rough painful dermatitis on their arms where the gloves fail to reach. Some had had it in varying intensity for years, but accepted it as the unavoidable fate of a fulling-room worker. A lanolin base acid protection cream did not wholly solve the problem, for it would rub off their forearms as the men worked on the felt. After considerable searching we found the answer in specially prepared sleeves of a waterproof acid-resistant material which reached from the upper arm to snug-fitting cuffs at the wrist. Our dermatitis cases now dropped off markedly, and those patients who did appear confessed they hadn't bothered with the cream and sleeve precautions.

No industrial nursing program would be complete without an eye for safety. The mill already had an active safety committee which met regularly to inspect the plant and submit a report to the superintendent. Five years ago the president of the mills suggested that each plant superintendent appoint a safety director to head such a committee of his own choosing. The present safety director in our plant is the personnel manager. His standing committee consists of those men he feels know the mill best —the night supervisor and the manager of the cutting shop. The plant foremen alternate in attending the monthly meeting, so that not only is each department represented at regular intervals but also each foreman's interest in safety is encouraged. Several times a year the insurance company engineer presents a safety film and talk to the entire group, stressing the foremen's responsibility in a safety program. Whenever the nurse in her tours of the mill notices any condition which needed the committee's attention she reports it to the safety director, since, as personnel manager, he always worked closely with her on employee health matters. It speaks well for their program that the felt mill was one of three industries to be awarded a medal by Liberty Mutual Insurance Company several months ago for having a record of 200,000 man hours of work without a lost-time accident. Since that award they have had only one such accident in a period of seven months, a vast improvement over former accident rates.

This is just the beginning of our work at the felt mill. Our three months' trial period is long since past, and we now have a permanent place in the medical program at that plant. We have been there more than a year, have set up our records under medical guidance, have standardized the first aid, and followed through on many cases needing medical attention. Throughout our initial gropings into this new field tremendous help has been given us by Dr. Albert S. Gray and Rowena Belden of the Connecticut State Department of Health, Bureau of Industrial Hygiene.

We were fortunate to try our wings in an industry so eager to improve their medical program. Best of all, from a public health point of view, it has rounded out our program in this little community and put the public health nurse on a confident and friendly footing among its reticent people.

Faculty Preparation in the Health and Social Components of Nursing

Suggested functions and preparation of the school nursing faculty member responsible for the promotion of the health and social components of nursing*

GRANTED that the basic concept of nursing includes prevention of illness, promotion of health, and care and rehabilitation of the sick, and that the present goal of nursing is to provide an adequate amount of this type of nursing care to all individuals, those engaged in nursing education are responsible for preparing students to function in this broad capacity.

It is recognized that independent schools of nursing with at least a two-year college admission requirement, as suggested in *Curriculum Guide for Schools of Nursing,* or with a full collegiate program, can go further in developing health nursing skills than many of our present hospital schools, which require only high school graduation for entrance. However, this Committee believes that any school which is to justify its designation as a school of *nursing* in the true sense, must develop appreciation, attitudes, and at least beginning skills of health nursing. Although the ultimate responsibility for this broad base of nursing service and nursing education rests with the director or dean of the school, she needs the assistance of the entire staff and faculty and, in many instances, the assistance of a nurse especially experienced in the health and social implications of nursing. Practical suggestions for the use of such assistance is the purpose of this committee report.

Teaching of the health, preventive, and rehabilitative elements of nursing, as well as the curative elements, must be started early in the basic curriculum and related to every function and every appropriate learning situation.

Students should see this "complete" nursing care given and planned in relation to every patient if such a concept is to become meaningful. This calls for close coordination of the hospital nursing service with other nursing services in the community, simple but effective methods of referral and communication between these nursing services, and full appreciation and use of these channels by all of the nursing service and instructional staff.

Such a program of nursing education calls for full utilization of the educational facilities within the hospital, and careful supplementation within the rest of the community. The selection and use of such facilities devolves primarily upon the teaching and administrative staff, who work jointly with the staffs of hospital and other community agencies. It is essential, therefore, that the entire instructional and administrative staff should have had satisfactory orientation to public health, public health nursing, and community welfare programs.

Until such time as all faculty members have had this preparation, it would seem desirable to delegate to some one member the responsibility for assisting and guiding, through proper administrative channels, other faculty and instructional staff in the interpretation and inclusion of the social and health components of nursing. This person should be well qualified in both public health nursing and in teaching or administration in a school of nursing. Which of these qualifications should be given greater weight depends upon the particular needs and resources and the stage of development of a given

school, and also the way in which the individual is expected to function. (See page 352.)

TITLE AND STATUS

Promotion of the health and social elements of nursing may call for adjustments throughout both the school and hospital service. It is therefore recommended that the faculty member designated for this responsibility be given such status and title as would enable her to function in both the service and school of nursing programs.

The title "associate" or "assistant director," or a similar one carrying the status implied in it, is suggested. The Committee has considered many subtitles, such as "Responsible for promotion of health nursing," "Responsible for health coordination," "Responsible for home and community coordination." It has concluded, however, that the matter of subtitles should be left to the individual school.

In a small school of nursing, or in a large school during an experimental period, a part-time appointment for this position might be made. One nurse might divide her time between two or more schools, or the school might purchase a specified amount of time of a local public health nursing supervisor. In either case, the same principles of function, status, and preparation should be considered.

RANGE OF FUNCTIONS

The functions and responsibilities of the faculty member responsible for promoting the health and social components in nursing as presented below are comprehensive in scope and represent a range of possible functions. Obviously, at no one time could the nurse holding this position function in all capacities listed. Not every person so assigned will be prepared to assume the entire list of functions. There would be no need for her to function in those areas where adequate attention is already being given to the social and health elements of nursing. She would then concentrate her efforts in other areas where these concepts are less clearly defined or in need of development. Briefly, the work would be started in various areas of service and teaching, and in many different ways. Each situation will call for its own appropriate selection of activities and plan of development.

SUGGESTED FUNCTIONS AND RESPONSIBILITIES

NURSING SERVICE PROGRAM

I. *Functions in relation to the program as a whole*

A. Policy making

1. Assist in developing the hospital service as a coordinated unit of a larger community health plan.

a. Help study community needs for complete nursing service for all individuals through participation with other hospital and community representatives, in joint planning groups, such as child health, orthopedics, tuberculosis, and similar committees, and community nursing council.

b. Study the hospital nursing services and participate—through community work with representation from administrative, nursing, medical, and medical social service staffs—in developing plans for improvement of services offered in terms of community needs.

SCHOOL OF NURSING PROGRAM

I. *Functions in relation to the program as a whole*

A. Policy making

1. Assist in developing the social and health concepts of nursing throughout the basic curriculum.

a. Help define the health and social aims of nursing, plan methods and select areas of appropriate content to reach them.

(1) Within the school through committee and faculty channels.

(2) In national, state, and local organization work.

b. Assist in determining the sequence of experience and courses in order to promote the learning of the student, yet safeguard both patient and student, especially when having experience in the community agencies.

NURSING SERVICE PROGRAM	SCHOOL OF NURSING PROGRAM
	(1) Participate in faculty meetings. (2) Work with committees, such as curriculum committee or the council of affiliating agencies.
c. Promote continuous nursing care for all patients through the development and use of an effective nursing referral system between the hospital and other community agencies. Help work out plans in joint committee representing administrative staff of agency and hospital administrative, medical, nursing, and social service staffs. Give individual assistance in its use.	
2. Participate in committees and staff meetings in formulation of personnel policies which will help to secure a staff increasingly able to plan and give nursing care, in its fullest meaning, as part of community health plans.	2. Participate in committees and faculty meetings to formulate personnel policies which will help to secure faculty increasingly able to develop and interpret the social and health concepts in nursing.
a. Assist in the recruitment and selection of such personnel.	a. Assist in the recruitment and selection of such a faculty.
b. Assist in planning for professional growth in the understanding of the social and health concepts in nursing.	b. Assist in planning for professional growth in the understanding of the social and health concepts in nursing.
c. Assist in planning a health service for all employees to protect the employees, patients, and students.	c. Assist in planning a health service for faculty members for the protection of faculty, students, and patients.
B. Interpretive functions	B. Interpretive functions
1. Promote further understanding of the social and health components of nursing—aims, methods, and content—on the part of all administrative, medical, nursing, nutrition, and medical social service staffs in the hospital through individual conferences, participation in committee work, group conferences, and staff meetings.	1. Promote the further understanding of the social and health concepts of nursing—aims, methods, and content—on the part of the entire instructional staff, through individual conferences, participation in committee work, group conferences, and faculty meetings.
2. Promote increasing understanding between hospital personnel and public health personnel through mutual sharing of problems, information, and changes in policies. Assist with discriminative planning of attendance by staff members at staff meetings of other selected agencies, joint committee meetings, joint study groups, and lectures of mutual interest.	2. Promote the understanding of the aims and content of the basic curriculum on the part of agencies cooperating in the instruction of students during affiliation, observations, and lectures, particularly in relation to the health and social aspects of the curriculum.
II. *Direct responsibilities*	II. *Direct responsibilities*
A. Work individually and through committee work with the hospital service staff to improve the health and social components of nursing care given all patients, including needs of the family as well as the patient.	A. Promote throughout the curriculum the teaching of the social and health concepts of nursing both in class work and clinical practice.

FACULTY PREPARATION

NURSING SERVICE PROGRAM

1. Assist in selection, preparation, and revision of factual material for use as teaching content for patients which will be scientifically sound, as well as meet the approval of medical, nursing, and nutritional staff.

2. Act as consultant in patients' problems which relate to the social and health elements of nursing care.

3. Assist in collecting and promoting use of demonstration materials for teaching patients within the clinical services and out-patient department.

4. Promote the better use of the patient's whole record and family record as a means of integrating the social and health concepts of nursing and of improving the actual nursing care given.

5. Promote better and more appropriate use of the medical social service department and related community health agencies on behalf of patient care.

6. Give special attention to promoting high standards of nursing care and integrated community nursing care in the out-patient department.

7. Assist in developing individual and group teaching plans for patients and/or their families.

8. Promote or cooperate with other committees in the simplification and communitywide standardization of procedures in order to clarify and promote patient's cooperation in his own recovery and rehabilitation.

SCHOOL OF NURSING PROGRAM

1. Assist other instructors to emphasize the social and health aspects of nursing within their courses and assist them to keep informed of newer developments in community health affecting their teaching.

2. Teach those courses or units with considerable health and social content for which the health coordinator is the best qualified person in the local situation.

3. Participate in ward and out-patient teaching program by conducting some of the conferences with students or graduates regarding patients; give assistance with nursing care studies; participate in symposia and other types of cooperative teaching.

4. Assist with supervision and guidance of student experience in the out-patient department to the end that each recognizes and experiences integrated community nursing plans for all patients.

B. Assist in the selection and planning of experiences in community agencies which are to assist in developing health and social aims of the curriculum.

C. Assist with the supervision and/or guidance of the student health program through committee work, group conferences with students, and individual conferences with students, staff, and parents.

D. Assist in student guidance and placement, particularly as it relates to public health nursing as the choice for graduate experience.

NURSING SERVICE PROGRAM

SCHOOL OF NURSING PROGRAM

1. Maintain close contact with personnel standards, opportunities for preparation or opportunities for employment in public health agencies.

2. Guidance conferences with students or graduates.

RECOMMENDED QUALIFICATIONS

For all nurse members of the school of nursing faculty and those participating in the education of the student nurse it is recommended that their preparation should include, as soon as possible, university courses in: (1) introduction to community organization and welfare (2) orientation to public health and public health nursing, including field observation and experience.

For the faculty member responsible for promotion of the health and social components of nursing (full or part time), it is obvious that, because the functions recommended for this faculty member are broad in scope, involve working with a wide variety of persons and necessitate initiation of adjustments in firmly established habits and policies, personality and maturity should be major factors in the selection of a successful appointee. In addition, it is recommended that the following academic and professional qualifications be met by future appointees and be reinforced as soon as possible by present appointees. It is hoped that clarification of this position and these definite recommendations concerning the type of preparation considered advisable may encourage many capable young women to plan a progressive series of steps toward qualifying for this type of position.

1. *General education:* A baccalaureate degree.

2. *Basic nursing education:* Graduation from a state-accredited school of nursing offering a well-integrated curriculum providing broad clinical experience in medical, surgical, pediatric, obstetric, communicable disease, and psychiatric nursing.

3. *State registration.*

4. *Advanced university preparation:* Completion of (*a*) an approved public health nursing program of study; or (*b*) a major program in teaching or supervision in schools of nursing.

If (*a*), then, in addition, courses in supervision, teaching, guidance, curriculum construction, and introduction to school of nursing administration.

If (*b*), then, in addition, completion of the professional content of an approved public health nursing program, as well as courses in guidance and curriculum construction.

5. *Experience:* A minimum of five years of nursing *supervision and/or teaching* in: (*a*) a clinical department or unit of a hospital and (*b*) a public health nursing agency.

The major portion of this time should have been in a public health nursing agency.

---

*This work of the Joint Committee of the NLNE and NOPHN on the Integration of the Social and Health Aspects of Nursing in the Basic Curriculum is presented to the profession, not as a finished or static product, but as a preliminary report to be used as a basis for discussion, experimentation, and criticism. The Committee will welcome comments directed to it through Adelaide A. Mayo, executive secretary, National League of Nursing Education.

The members of the committee are: Irene Carn, N. Y.; Pearl Coulter, Colo.; Lucy Dade, Tenn.; Winona Darrah, N. J.; M. Olwen Davies, Calif.; Mary Edgar, N. Y.; Harriet Frost, Pa.; Mary Harty, N. Y.; Virginia Henderson, N. Y.; Martha Johnson, Md.; Bernadette Kraus, N. Y.; Rita Miller, La.; Agnes Olsen, Conn.; Elisabeth Phillips, N. Y.; Minnie Pohe, Washington, D. C.; Mrs. Elizabeth Sewell, N. Y.; Elizabeth Tennant, N. Y.; Hedwig Toelle, Conn.; Mrs. Leah B. Bryan, N. Y., chairman.

This article is appearing also in the July issue of the *American Journal of Nursing*.

A VNA Assists with Integration

By CONSTANCE ROY, R.N.

FOR years the relationships between the Orange Memorial Hospital School of Nursing and the Visiting Nurse Association of the Oranges and Maplewood, both located in Orange, New Jersey, has been unusually good. This cooperative regime began in 1926 when the Visiting Nurse Association gave a two-months' public health nursing affiliation during the senior year to all students. Many of the present hospital supervisors and head nurses had this experience and comment favorably on its value.

The hospital automatically refers all ward patients to the Visiting Nurse Association for follow-up in the homes. The clinic of the hospital also has always worked closely with the Association. A visiting nurse attends the maternity clinic to interview patients. A report is sent to the Visiting Nurse Association on each patient's visit to clinic.

Cooperation exists from the top down. The director of the School of Nursing is a member of the Nursing Committee of the Visiting Nurse Association and the director of the Visiting Nurse Association is on the School of Nursing committee. This makes for complete understanding by both directors of the existing problems. The close working relationship is very essential to the development of joint programs.

The faculty of the school is well prepared. Every encouragement is given by the director to all nurses to take post-graduate courses. This is possible because of the proximity to New York, the fact that time is given for study, and that the ambitious receive commendation. Some of the doctors on the Visiting Nurse Association Medical Advisory Board are also on the hospital staff.

The School of Nursing is approved by the National League of Nursing Education, recognized by the New York State Board of Nurse Examiners, and both hospital and agency have fairly stable staffs. The directors of both agency and hospital, as well as the School of Nursing educational director, have given many years of service.

Because of the national plan for acceleration of nursing education, and shortage of staff, it was decided to discontinue the affiliation period. It had long been realized that along with the affiliation there should have been a plan to integrate the social and health concepts of nursing throughout the basic nursing curriculum beginning with the preclinical period. If a choice was necessary between integration throughout or an affiliation, the former seemed more important. Sometime when things are normal again, we hope the affiliation can be added to total integration further to enrich the student experience. The students need experiences to develop a health point of view and a knowledge of community agencies long before their senior year. Each student, in the early stages of and throughout her nursing school phase, should have as broad a nursing education experience as possible.

After considerable thought and consultation with the NOPHN on the subject, a plan to integrate the social and health concepts of nursing throughout the curriculum was inaugurated in September 1942. From the beginning, the planning started with the directors, the educational directors, and followed through to the faculty and supervisors. All the key peo-

Miss Roy is supervisor of the Visiting Nurse Association of the Oranges & Maplewood, Inc., Orange, N. J.

ple involved in student education were in at the start.

One supervisor from the Visiting Nurse Association was chosen to act on a part-time basis as the public health instructor in developing the program. She obtained help and advice from the Visiting Nurse Service of New York, New York Hospital School of Nursing, and the New Jersey State Board of Nurse Examiners. The time originally designated was two half days a week for which the hospital paid. In February, the time was increased to two full days a week, needed to continue the development of the program and allow for more effective work. The director of the School of Nursing plans eventually to have a full-time public health instructor on her faculty.

The public health instructor gradually moved the formal teaching from the agency to the hospital. This means economy of supervisory time, while it also brings the class work where it belongs into the basic curriculum. It should never have been a separate entity, as most of us in public health and nursing education now realize.

The public health instructor gives a lecture in the preclinical period to explain the relationship of personal health to public health. This is a part of the personal hygiene course. At first the formal classes were given in a block during the second year, but now each class is a part of the course to which it relates. Three other lectures are given in the preclinical period with the purpose of introducing the student to the opportunity afforded for teaching the ward patient, the realization that this individual is a member of a family unit with various problems, and the community resources which may be helpful to this patient.

In the second half of the first year, the student has two lectures dealing with the teaching opportunities present in all care of patients with long-term illnesses and orthopedic conditions. During the second year, four hours are devoted to discussing the tuberculous patient, the maternity patient, and community resources for keeping a child well through the infant, preschool, and school periods. These lectures are integrated with the units relating to these subjects.

The last two hours, given for vocational guidance purposes in the first half of the third year, briefly cover the preparation of and qualifications for public health nurses in the various fields.

Besides the formal classes, the public health instructor works with the students on an individual basis, both on the wards and in planned conferences. She discusses with the students home problems of the specific patients being used for case studies. Material from the Visiting Nurse Association records is available for their use. Those interested in entering the public health nursing field ask for guidance and direction.

A medical and nursing ward teaching clinic is held each week. The student who is responsible for the nursing clinic may confer with the public health instructor to discuss the family problems. The hospital social worker will also confer with the student on cases active with the social service department.

The present senior class has had a part of their sanitation course taught by the public health instructor. In these classes, the history of disease control, prevention of disease, health care, industrial hygiene, and housing is given. This year a profitable excursion to a Newark housing project was made by both sections of this class.

During the clinic experience of six weeks, the students have three conferences besides those with the clinical supervisor. These are given by the venereal disease nurse, the psychiatric social worker, and the public health instructor. They attempt to show the student how she can improve the health of the clinic patient, the way in which the venereal disease patient is handled, and mental hygiene problems that may be encountered.

In the third year, all the students have a two-weeks' observation period at the Visiting Nurse Association. This serves to give them some appreciation of the community nursing program, stresses the use of the home visit for improving family health, and demonstrates the cooperative effort of all social and health agencies.

During this time each student participates in the daily work of her senior adviser, observes at child health conferences and school health activities. Two case conferences are held during the two-week period, at which specific families are discussed. The student writes a brief evaluation of this experience. The following paper written by a student amply illustrates the value of the observation period to the undergraduate:

From my observation period with the Visiting Nurse Association, I have learned not only the practical adaptation of nursing in the home under home conditions, but also the effect illness and invalidism produce in the family and in the individual family members. The problems arising from illness have been brought more clearly to my mind than they had been previously in my work in the hospital. I have seen such problems as:

1. The financial difficulty occurring when the wage earner of the family becomes ill.
2. The difficulty in arranging proper care for the children when the mother becomes ill.
3. The difficulty in instructing uncooperative or unintelligent persons in the care of those ill.

I have also learned the fear of the hospital manifested by many of the older patients. I was surprised to see how many acutely ill patients were being cared for at home because they refused or could not afford hospitalization. I learned how many new mothers came home from the hospital inadequately instructed in the care of their babies, and how many mothers of preschool children were unaware of the importance of vaccination and immunization.

I enjoyed my observation period with the Visiting Nurse Association because of the many opportunities it afforded me for added knowledge; because it gave me an opportunity to observe my patient, his family, and his environment more closely and conclusively; and most of all because it gave me an opportunity to instruct my patient and teach him about his care and his illness along with the nursing care I helped the public health nurse render.

In addition to her work with students, the public health instructor discusses the program with the head nurses and faculty. This past year we have started group conferences with the head nurses to clarify and explain the program as a part of the student curriculum. The meetings have been helpful to us in planning how to meet the student's needs.

It is generally felt by the group that a half day or a day of field observation in the home during the preclinical period would be a valuable student experience. To date, this has not been possible. It would give the student early in her experience an insight into her patient's problems and an understanding of the environment from which that patient comes.

The public health instructor has found this new work stimulating and satisfying. Its success is due to the excellent cooperation between the School of Nursing and the Visiting Nurse Association. The hospital nurses are an integral part of the total community health program, so it is imperative that they teach positive health to all patients.

Let's Finish It with the Seventh!

The now-famous photograph of the four battle-weary Marines planting the flag on Iwo Jima has fired men's minds all over the country.

Before the instant of time recorded by the photograph could become a reality 4,100 American boys gave their lives, and almost three times that number were wounded. Because it symbolizes the superhuman efforts of our fighting men on all fronts, because it represents their unflagging and invincible courage, this picture most fittingly strikes the keynote for the MIGHTY Seventh War Loan.

Buy Bonds!

A Blueprint for Lay Participation

By GRACE N. KIECKHEFER

LAY participation in public health nursing programs has been a matter of increasing importance for many years. The war has more or less forced the issue upon the attention of both nurse and layman, and war needs in a large measure are presently shaping the type and extent of lay participation. But even before these emergency years, the need was felt for a more enlightened and responsible public interest in health problems, and forward-looking public health leaders, in spite of their absorption in the huge task now in hand, are realizing the implications of the present situation for the future. They rightly urge that now is the time to seize upon war-aroused public interest and enthusiasm and, before it can be dissipated in a myriad of postwar activities, to shunt it into permanent channels of participation and assistance in our public health nursing programs.

However, many people, laymen and professionals alike, who have had no prewar experience with lay participation, nor opportunity to investigate its possibilities in a peacetime setup, are at a loss to know just how to go about this particular problem of "reconversion." Perhaps a brief description of a project in lay participation which grew out of World War I may be a blueprint to help interested persons today in their attack on this problem. It may serve to show how a desirable program can grow spontaneously and naturally in answer to community needs, with only the spirit of open-mindedness and good will and a desire for service in the best interests of the public as the foundation stones.

May I introduce the Waukesha County Council for Child Welfare, one of Wisconsin's larger lay groups, which, with over 25 years of service to its credit, is no longer an experiment in lay participation but an accomplished fact.

Waukesha County is a prosperous agricultural area contiguous to urban Milwaukee County. During World War I, the usual patriotic projects flourished, such as the County Defense Council, Red Cross units, and other similar groups. Soon after the war ended, a small group of women, who had enjoyed the activities and associations of war service, felt that the fine spirit of cooperation and inter-community organization which had been developed should not be allowed to dissipate itself, but should be fostered and turned to good account in some peacetime project. Accordingly, the group decided upon child welfare as its theme and for its first project, the securing of a county nurse and the establishment of her office. The project was a success. In other words, a lay group, with small professional guidance, secured for their county a qualified public health nursing service. The story of the growth of the county nurse's work is also the story of the Waukesha County Council for Child Welfare.

The nucleus of today's large Council met in the delightfully informal, sociable way that characterizes all Wisconsin rural organizations; the Council of today still meets in an informal, friendly atmosphere. The Council has kept its organization simple—with little emphasis on involved bylaws and parliamentary red tape—for a reason. They want people to join the Council. They want to make it easy and pleasant for people to belong. The plan

Mrs. Robert Kieckhefer of Brookfield, Wisconsin, is chairman of the Education Committee of the Milwaukee VNA and is also on the program committees of the Wisconsin SOPHN and the 4th and 5th District Unit.

is easily copied or adapted to various local situations.

There are two classes of memberships, organization and individual. Organizations pay a minimum of one dollar a year as dues, but many of them make very substantial contributions to the Council treasury. All and any organizations are welcome as members—women's clubs, fraternal orders, farm groups, church or school societies, and even such exotically named clubs as the "Snappy Stitchers' Sewing Circle" and the mysterious "Merton Lion Tamers." Organizations are urged to send representatives to the two open meetings of the Council, when interesting programs are presented, in addition to reports of work done. Individual members pay a minimum of fifty cents a year; many of them belong to supporting organizations, but wish to do their individual bit.

From the membership at large, a Council of Representatives is chosen, including at least one key woman from each community in the county. She is generally the woman who has shown the greatest willingness to work and to assume responsibility for her community. Half a dozen founders constituted the first little Council of Representatives. It is self-perpetuating and self-expanding, and now includes about thirty-five members. From this group, in turn, the officers and chairmen of standing committees are elected.

SINCE THE county nurse was its creation, the Child Welfare Council assumed responsibility for many things which meant success or failure in her pioneering program. As in most beginnings of county nursing work, the nurse's budget included little but her salary, and the Council supplied her with baby layettes and other clothing, blankets and bedding, loan closet materials, cod liver oil, and other items. They paid for extra stenographic help and supplied a "contingency fund" so that the nurse need not dip into her own pocket when confronted by emergencies at hours when county authorities were not available. In short, whenever the nurse found herself stopped by some lack, she had only to say, "I need . . . Could you get me . . . " and the Council hastened to supply the need.

A recent visitor to a Council meeting, hearing impressive reports of work done, asked how the members had the vision to plan all this. The answer, of course, was that the Council exemplified the theory of learning by doing—doing the immediate task at hand. Vistas opened up along the way and the vision grew with the Council. The pioneer nurse, Mrs. Emma Higgins, was a woman of vision who did not hug her job to her own bosom but, recognizing the importance of delegated tasks, continually broadened the scope of her work, publicized it, and made it an integral part of the consciousness and activities of a constantly expanding circle of county women. Behind her, too, was a fine County Health Committee. The woman member (specified in Wisconsin statutes) and the moving spirit of this Committee, until her retirement a few years ago, was Mrs. Maud Blackstone, known throughout the country for her work with the National Federation of Women's Clubs and, in her state, as "Wisconsin's best-loved clubwoman." Mrs. Blackstone was one of the founders of the County Council for Child Welfare and a liaison officer between it and many other groups.

Twenty-five years ago in a conservative rural area, social experiments were looked upon with a skeptical and slightly jaundiced eye, particularly if the experiment made large demands upon the public treasury. As each November rolled around, the month of county board meetings, the nurse's office was apt to fare ill in the Battle of the Budgets. County supervisors were more familiar with, and therefore more favorable to, items for highway maintenance, for the construction of new hog barns at the County Farm, for combatting hog cholera or Bang's disease in cattle. Hog and cattle welfare struck a more familiar note than child welfare. Public health nursing was still on a dubious footing when the depression struck.

In Waukesha County, as everywhere else, the lean years soon produced a paradoxical situation, a demand for reduced

taxation and the elimination of every service and employee that could possibly be spared and, on the other hand, a greater need than ever for certain services—chief among them, public health in general and child health in particular. The county nurse was soon faced with the need for funds to carry on. She knew that one lone woman could wield no political power. But in every town and crossroads community she knew she had an ally who would plead her cause, and she presented her case to the Child Welfare Council.

The Council was already doing a heroic piece of work. There was a certain town over in a corner of the county which had once been a railroad center, with large repair shops and yards. It was a substantial, home-owning community. With little warning, the yards were closed, the shops dismantled, and the village that lived by them was left stranded. There was no other source of employment in that section nor was there any work to be found in neighboring cities, and no market for homes and business properties. "Relief" supplied food, clothing, and other necessities of existence. But children were growing up without dental care and routine school inspections by the county nurse revealed that an appalling number needed corrections for eye or ear defects, needed tonsils and adenoids removed, needed orthopedic appliances or special treatments of various sorts. This village was by no means an isolated example; similar conditions existed in other sections, but this was the most flagrant case and the one where the County Council began its campaign. When the Council representative from this railroad town told about the shocking conditions in her community and the nurse had added her testimony, the Council took immediate action.

A lay group, not having to wait for any ponderous official wheels to get into motion nor any official sanctions to be bestowed, the Council authorized the nurse to have the worst cases corrected at their expense. Their treasury was limited; they conducted a campaign for more memberships and more contributions from organizations. Still it was the proverbial drop in the bucket. They surveyed conditions throughout the county. They realized that their fund-raising efforts could not keep up with the growing volume of work for children which the survey uncovered. And so these women of the Council went to their County Board of Supervisors, and in a year when budgets were being cut right and left, they dared to ask for a county health program, an annual program that would cost thousands of dollars more than the nurse and her whole office had cost heretofore. The County Health Committee lined up doctors, dentists, and hospitals to fix a uniform scale of fees and charges. Not without some strenuous political campaigning, the program went through.

WE HEAR much about political "pressure groups" in the bad sense of the term. No doubt the County Council for Child Welfare became a pressure group, for certain things cannot be obtained in our political scheme without such organized effort. A county nurse cannot play politics; she might endanger her work and opposition to her personal efforts could become opposition to her program. Therefore a nurse needs a lay group behind her when political action is the means of securing her ends. The Waukesha County program of corrections met opposition throughout the years of the depression. Since the County paid only one half the cost and the rest was charged back to the town or village where the patient resided, Council members often had to fight locally to bring the town boards into line. For three years the county finance committee groaned at the sight of the child health item in the budget, but the fourth year showed that the peak had been passed. When good results began to show and the County began to receive pats on the back from state and federal bureaus, the County Board began to feel pleased and expansive about what they had done. So while they felt that way, the County Council for Child Welfare persuaded them to give the nurse an assistant and clerical help as well, and a bigger and better office. Waukesha

County had become definitely health conscious during the depression.

During these years, the county nurse was also forced to be a part-time social worker, doing actual case work on other than health cases. In most counties where an adequate social welfare staff is not maintained, and they are legion, the county nurse is expected to do many chores beyond the requirements of her job, and she does them because they need to be done. The Council again relieved the nurse's load when they brought about the establishment of the County Children's Board in Waukesha County, with a paid children's worker.

The County tuberculosis program has also been a major project for the Council. The annual reports of the county nurse record its steady expansion. With a well organized plan for the testing of school children already in operation, the Council is now turning its attention to better follow-up work with adults. Although the rapid turnover in school personnel due to war conditions has prevented a one hundred percent success in the testing of all teachers, janitors, cooks, and other personnel employed in schools, the time is not far off when this will also be an accomplished fact. To expedite this program, the Council has paid for x-rays of school personnel as well as mileage bills for chest specialists. Years ago, the Council took over the Christmas Seal sale in the rural county which then brought in a meager return. After doubling and trebling the sale, the Council finally produced its own Waukesha County Health Seal, designed annually by a school child in the county in a contest sponsored by the Council. The Council also sponsors prizes for the healthiest boy and girl contest, part of the 4-H health work.

THUS the Council has brought the nurse and her work into the rural county. In the cities of Waukesha and Oconomowoc, in each little village or wide place in the road, sleepy little towns like Brookfield, Elm Grove, Sussex, or Lannon or Delafield, through which countless travellers pass to the lovely Waukesha County lake region, there is a very wide-awake Council representative who keeps an eye on her community, not just on the children, but on all the factors that affect their welfare and that of the whole community. In just a few minutes over the telephone the nurse can put her finger on conditions in any part of the county. She can get information that would take hours of her time and gallons of precious gas if she had to go after it personally. She can sound out a community's opinions. She can convey information and advice with a minimum of effort. She can delegate to local groups preparatory and educational work to smooth her path and speed up her professional work. In every community she finds a friendly, cooperative, progressive, and really competent group waiting to assist and supplement her efforts.

Through the Council many drives and campaigns are organized and coordinated, removing again from the nurse's shoulders many of those worthy, but time-consuming little extras that somehow find their way to the county nurse's desk. Council women realize that the nurse must be freed for the duties which she alone can perform, for her job is no sinecure. Her duties include these services: communicable disease control, immunization programs, tuberculosis program, maternity service including service to wives of servicemen in the lower pay brackets, infant and preschool crippled children, school health including school inspection and the furnishing of vast quantities of educational materials, and educational work with adults including clinics, classes, lectures, and conferences with interested groups.

At present the Waukesha County nurse's office is understaffed. The women of the county realize that nursing service in their section is a war casualty, and that lay assistance must go as far as possible to fill in the gaps. They are seeing the benefits brought by their efforts to raise the health standards of the county through these past twenty-five years, for their county is in excellent condition in regard to health and can stand a period of lessened services. However, the Council has its thoughts on the future. They know that Waukesha has outgrown its

prewar staff and program. They have studied reports on the number of nurses needed to handle effectively their population numbers. When nurses are again available they will want more nurses, and they will work for more nurses.

There is a thought in this that should strike a responsive note among those who are interested in the future of the nursing profession. Nurses are now at a premium. But what of our much discussed postwar world? Servicewomen, as well as servicemen, worry about future employment, and of possible oversupplies of workers in their particular fields. We have scarcely trained enough workers for the war needs. Have we, however, overtrained for the peacetime market? It is obvious that if we are not to have a serious unemployment situation among nurses after the war, we must create more demand for nursing service, more jobs for nurses. It is equally obvious that the nursing profession of itself cannot create those jobs. But a general public alive to its own needs and best interests can create the demand for nursing service that will develop the jobs. For this reason it is important that nurses recognize the value of having lay coworkers in the National Organization for Public Health Nursing and in the state organizations. It is not always the professional who can best see new horizons in a profession. Many times, as we say, she cannot see the forest for the trees. She may well, in times like these, be too close to her job, too busy, too rushed, too tired for study and investigation of new ideas. She may be bound by limits of time and space, as in our larger rural areas. She must learn to be an administrator, an instructor, and a delegator of tasks. She need not fear that laymen will usurp her proper functions. On the contrary, once given a vision of what an adequate program of public health nursing can be, they will build up her job to heroic proportions. Enlightened lay support is the very best job insurance that the nursing profession can develop.

NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Lucy C. Perry, B.S., M.A., school nursing supervisor, City Board of Health, Toledo, Ohio

*Annette M. Sheehy, B.S., assistant district supervising public health nurse, New York State Department of Health, Albany, N. Y.

Mrs. Helen M. Haake, industrial nurse, A. Finkle & Sons Company, Chicago, Ill.

*Mrs. Blanche W. Crawford, B.S., staff nurse, Bremerton-Kitsap Department of Public Health, Bremerton, Wash.

ASSISTED PLACEMENTS

*Kate O. Hyder, B.A., M.A., director, nursing service, Chicago Maternity Center, Chicago, Ill.

Vera L. Thompson, B.S., staff nurse, San Joaquin Health District, Stockton, Calif.

Mrs. Lazarenah M. Payne, B.S., staff nurse, Community Service Society, New York, N. Y.

*The NOPHN files show this nurse is a member.

The Challenge of Tuberculosis

By CLARA OSGOOD VEDDER, R.N.

WE ALL know that first impressions are extremely important in shaping our attitudes toward a new situation. As public health nurses, we are among the first to meet a newly diagnosed tuberculosis patient and his family. What are we doing with this challenging opportunity? Are we creating attitudes that will help our patient go to the sanatorium with an understanding of his disease and a hope for the future? Or will he be one of the all too frequent patients who return home in a few weeks seeing no reason why he can't "cure" just as well at home?

This latter belief on the part of the patient and his family, coming from a complete lack of understanding of the nature of the disease and the reasons for the methods of cure instituted by sanatoria, physicians, and public health nurses, is the beginning of so many long, losing fights between man and the disease. In these instances, the patient sometimes in apparently good health returns to work. At other times the germs get the upper hand and he again submits to hospitalization for a short period.

Such a situation is a double menace to public health. The patient himself has developed a chronic condition with varying degrees of fatigue, irritability, and other symptoms which prevent him from ever doing his best work. And we have a potential public health hazard constantly present in the community. It is a hazard that is twofold in itself for there is the obvious damage done by the actual spread of the tuberculosis germs and the undermining effect of this patient's indifferent and perhaps bitter attitude toward our community's anti-tuberculosis campaign.

A carefully planned educational program for all new tuberculosis patients and their families is our answer to this challenging situation. An ideal program should include education in the following subjects: (1) basic knowledge of the disease (2) protection of the family and (3) factors in treatment. In approaching this subject we should keep in mind that tuberculosis usually strikes in the dark and that the patient seldom feels acutely ill.

An outline of the material we should teach is listed below. With each subject there is given a list of references that will prove invaluable both to us and the patient. Where one particular phase of a subject is especially well presented in a pamphlet, that too is mentioned.

PROTECTION OF THE FAMILY

In discussing how to protect the family we should first explain that the source of infection is from the droplets of moisture from the nose and throat expelled in coughing and sneezing. When the patient and his family understand this they will more willingly and intelligently cooperate in the suggestions we will make for further prevention of spread of the disease.

Suggestions for the patient

Proper use of tissues
Complete set of personal toilet articles
No kissing
Everything kept away from the mouth and face
Sleeping alone
If bathroom privileges (dental hygiene over toilet or in special basin)

Suggestions for the family

Washing hands after every contact with patient
Disinfection of patient's dishes

Mrs. Vedder is known to readers of the Magazine as Clara Osgood, formerly of the staff of the Visiting Nurse Association, New Haven, Conn.

All personal waste and food scraps burned
Disposal of sputum if sputum cups are used
Bed linen cared for separately
No handling of patient's personal articles
Room cleaned with damp mop and cloths

As illustrative teaching material, use "How to Kill Tuberculosis Germs" (National Tuberculosis Association, 1790 Broadway, New York 19, N.Y.) to aid the patient in understanding the suggestions given to him and make it easier for the family to follow the instructions and demonstrations you will give.

TUBERCULOSIS, THE DISEASE

This subject can best be taught by pictures, illustrations, and literature.

It should include:

Anatomy and physiology of the lungs
A discussion of the tubercle bacillus—tuberculosis, a germ disease
Symptoms relevant to the patient—
Night sweats—their cause and prognosis
Cough—how to control it by sips of water, et cetera.
Hoarseness—its significance if any and possible need for whispering or silence
Sputum—never to be swallowed
Fatigue—a signal for more rest
Digestive symptoms—their cause and significance

As illustrative teaching materials, use:

Tuberculosis—Basic Facts in Picture Language—National Tuberculosis Association (for anatomy)
Diagnostic Standards—National Tuberculosis Association (for pathology)
What You Should Know About Tuberculosis—National Tuberculosis Association
Facts that Tuberculous Patients Should Know—Bronx Tuberculosis and Health Committee, New York Tuberculosis and Health Association
Big Little Things in Conquering Pulmonary Tuberculosis by S. H. Watson and W. R. Hewitt—Tucson Clinic, Tucson, Arizona (for symptoms)

TREATMENT OF THE DISEASE

As public health nurses we all know that in the treatment of tuberculosis the keynote to success is rest—physical and mental rest. The need of rest for healing a broken leg is easy for a patient to understand. It is our task to make him see this need just as clearly in its relation to the healing of lung tissue. Any activity, either mental, emotional, or physical, interferes with the healing processes. Activity of any kind increases the flow of blood through the lungs and so carries more toxins from the diseased lung area to the rest of the body. Activity also increases respiration in depth and frequency which interfere with mechanical rest of the local focus of infection in the lung. The patient will be better able to appreciate the value of rest when these factors are explained to him. Reinforcing these points with analogy and illustrative material pertinent to the individual patient will bring rich rewards.

The mechanics of rest (unless otherwise ordered by the physician) are:

Rest in bed, flat with two pillows, 24 hours a day
10-12 hours sleep at night
Rest hour—two hours after lunch
Adequate ventilation
Bed that is comfortable and convenient to table

Don'ts for the Patient

Never raise arms above head
No pulling, stretching, lifting, reaching
Sit up only with a back support
No loud talking or laughing
No activity continued until fatigue sets in

The only other factor in treatment necessary to teach in this early period of adjustment is diet. If the patient's appetite is poor or "finicky," he should be reassured that with rest his taste for foods will return and that "stuffing" is not necessary or desirable. The person who will prepare the meals should have detailed instructions on the foods to include in a patient's diet. These are of course only the foodstuffs that should be present in any well balanced diet with a slight increase in the protein allowance. The three regular meals a day may be supplemented with a glass of milk between meals and in the evening. Other foods should not be eaten between meals. Attractive and small servings are important.

Illustrative teaching materials are:

Big Little Things in Conquering Tuberculosis by Watson and Hewitt (for rest)

Home Care of Tuberculosis, Hints for the Patient by D. Deming—National Tuberculosis Association.

When the patient has been armed with this information on prevention of the spread of the disease, on the subject of the disease itself, and on its treatment, he is well prepared to enter a sanatorium and begin curing in earnest. This information alone is not enough and must be followed by much more instruction in the sanatorium. If, however, our teachings have been understood and have been accepted we have laid a firm foundation upon which later teachings can be built to make our patient's recovery strong and permanent. This is our problem. Are we accepting the challenge?

ADDITIONAL REFERENCES

Heise, F. H. C. 1000 Questions and Answers on Tuberculosis. National Tuberculosis Association, New York, 1941.

Krause, Allen K. Rest and Other Things. Williams and Wilkins, Baltimore, 1923.

Chadwick, H. D. and Pope, A. S. Modern Attack on Tuberculosis. Commonwealth Fund, New York, 1942.

Keeping Posted

A BULLETIN board is a strongly unifying force in any staff or organization, combining as it does visual education with a means of communication.

Recently, as part of the in-service training of our staff, a plan to utilize our bulletin board was worked out. It proved not only a splendid teaching tool but revealed much hidden talent.

Two nurses are responsible for the change of material on the board each week. In order that there might be spontaneity and no feeling of coercion, each nurse chooses her subject and working partner. The plan offers opportunity to show originality, ingenuity, interest, and resourcefulness. The staff quickly grasped the scope of the challenge and entered wholeheartedly into it. There has been a keen spirit of friendly competition, each team trying to outdo the other.

Results have been most gratifying. Perhaps the greatest single benefit is the stimulation of the staff to use the library and develop an ability to do research. As a consequence of this, the circulation of books from our professional library more than trebled itself in the first three months. Books, however, were not the only sources of information. Visits made to hospitals, laboratories, and the Medical Center proved most productive.

An effort was made to correlate the subjects with specific times; for instance, syphilis was the subject during the week of February 7 (National Social Hygiene Day); poliomyelitis in the week of January 22 (March of Dimes); and the health of the Negro in the week of April 1 (National Negro Health Week). Certain other diseases were featured in the time of their seasonal prevalence. The cause, symptoms, treatment, and public health aspect of each disease were brought out.

All kinds of visual aids were used, pictures, photographs, drawings, silhouettes, and a generous use of color. Typewriting, hand printing, and cut-out lettering were all employed. A surprising amount of originality was shown.

The motivating idea had been to stimulate professional reading and to develop initiative in the staff. The results have far outdistanced the original purpose. The material, scientifically yet simply presented, has been successfully used for health education purposes in schools, child health stations, and other suitable places.

We feel that the scheme has just begun to touch the reservoir of ability and enterprise latent in our staff and that it has untold possibilities.

CHARLOTTE M. INGLESBY, R.N.
VENEREAL DISEASE NURSING SUPERVISOR
CHATHAM-SAVANNAH HEALTH COUNCIL
SAVANNAH, GEORGIA

Field Teaching

By WINIFRED KELLOGG, R.N.

FIELD TEACHING is an imporant function of the Visiting Nurse Association of Detroit, an agency which has had student affiliates since 1919. An article entitled "A Staff Uses Opportunities for Growth" (PUBLIC HEALTH NURSING, December 1938, p. 713) describes the student new staff program of the agency and explains the use of the "field teacher." While many changes have taken place since 1938, in objectives, class content and methods, the overall plan of operation is the same, and the field teacher still carries a major responsibility for the success of the program.

The teaching staff of the agency, made up of field teachers, supervisors, consultants, and administrators, has evolved a guide which, used in conjunction with other materials, is helpful in the induction of new field teachers. Like all other agency materials which are the product of group activity it is continually in the process of revision to meet changing conditions and needs. We offer it for publication, not because we think it is particularly good, but because we have had many requests for it from people who find it useful and because in the evolution of our program we have profited by the study of materials prepared by others. Parts of the guide which seem to be entirely local in their application have been omitted.

FIELD TEACHER'S GUIDE—MARCH 1945

I. DEFINITIONS

A. Field Teaching is a supervisory function offering the senior staff nurse an opportunity to apply the principles of supervision in her relationship with students and to test her own capacity for supervision. Field teaching responsibility is assigned to assistant supervisors and senior staff nurses working under the direction of the supervisor.

B. Qualifications of Field Teacher. She must do excellent field work; be critically analytical of her own performance; have one year of university credit in public health nursing, including field work with another agency; one year of public health nursing experience; be interested in teaching students; be interested in maintaining the standards of this organization, regarding service to patients, staff and student relationships, staff and student growth.

C. Selection and Preparation of Field Teachers. The field teacher is selected by her supervisor with administrative approval. She first assists an experienced field teacher, studies Association materials and participates in conferences which are designed to teach her the mechanics of the job. Later she attends a series of group meetings on supervision, conducted by the case work consultant, or takes a university course in supervision. Eventually she does both. As she acquires facility in teaching students she is given increased responsibility for the program as outlined here. In early preparation she is expected to—

1. Study "Outline of Student and New Staff Program," re-read all student assignments, attend student classes as may be necessary. Check techniques with "Field Practice Manual."

2. Study "Field Teacher's Guide," looking up all references. Discuss with supervisor any part that seems not to be applicable and bring it up for discussion

Miss Kellogg is educational director of the Visiting Nurse Association of Detroit, Michigan.

in field teacher's meeting. Follow Guide with necessary adaptations in all work with students.

3. Attend and participate in field teacher's meeting. Keep a file of minutes. Start a field teacher's manual.

4. Familiarize herself thoroughly with district to which students will be assigned.

II. PLAN OF WORK

A. Office and District Orientation.

1. Purpose: to get acquainted with the student, help her to feel at ease and to understand what will be expected of her in regard to office routine, case and district management.

2. Method

a. Introductions (first day in station). Introduce student to staff, assign to desk, explain physical setup and day's program.

b. Office orientation conference (third day in station). Explain student's responsibility in relation to work assignment.

c. District orientation conference (second or third week). Discuss geography, socio-economic make-up, health conditions as revealed by statistics, resources, et cetera.

B. Field Demonstration and Participation (first day in substation and as necessary throughout experience). The field teacher carries the major responsibility for this important and difficult teaching. When a staff nurse has a good case she may be asked to give a demonstration, but she must be carefully prepared to do this teaching well. For inexperienced students each classroom demonstration and each field experience alone should usually be preceded by a field demonstration of a similar visit. Some students will not be able to make certain types of visits alone but will be able to learn through participating in visits made by field teacher if given sufficient help in preparation. Some students will require very little demonstration.

1. Purpose: to teach—

a. Approach to family and the development of working relationships. (Methods of securing a basis of understanding in simple and difficult situations—tactics used in delegating responsibility to families, et cetera.)

b. Interpretation of organization policies in regard to case management.

c. Intelligent adaptations of nursing procedures when necessary.

d. Value of records to nurse and family.

e. Method of getting around in district.

2. Method

a. Select cases with consideration for student's background, apparent ability and needs. Choose the simple case first and permit student to visit such cases alone before introducing her to the more complicated family situation. Before she makes visits alone to new patients give her an opportunity to participate in the opening of new cases and to see how the field teacher works with people who do not respond to her teaching as well as with those who do.

b. Pre-visit Conference

(1) Preparation. Give student the *case* and *family record* for patient who will be seen. Ask her to study them and related manual material.

(2) Conference. Discuss student's questions. See if she has been able to learn your objectives for case by studying record. Find out what she hopes to learn from the demonstration. If she needs guidance ask her to look for specific things and to be prepared to discuss them later. Help her to plan for travel. Plan with her for her participation in the visit.

c. Travel. Time may be devoted to general conversation. Stimulate student to discuss her nursing experience, showing your interest and discovering how you can help her use this affiliation to the greatest advantage. Before entering home, review briefly the points you wish to emphasize and review how student is to participate so she knows what to expect.

d. Visit. Introduce student as a nurse who has had hospital experience and is interested in your work in the homes, or as a graduate nurse who is taking a public health nursing course at the university. Do not make your teaching capacity too obvious. Bring student into visit as much as possible in accordance with plan. On each succeeding visit she should be more active.

e. Post-visit Conference

(1) Preparation. Complete recording of visit, including plan for next visit. Consider points student was asked to observe. Select material which will be helpful in teaching patient or family. Ask student to write up observations and questions, and make a plan for next visit.

(2) Conference. Discuss visit, considering especially student's questions and observations. If plan was carried through show how this was possible; if not, help her to analyze the reasons why it was not. Discuss future plan for case.

C. Student Visits Alone. Students learn by doing and lose their apprehension regarding field experience more quickly if they are given simple calls to make alone early in their experience. When there is any question of their understanding of procedures they should have return demonstrations in the office before making visits alone. The *student,* not the field teacher, should be the *actor* in this return demonstration.

1. Purpose: to give the student an opportunity—

a. To gain experience in entering homes and giving patients essential service.

b. To test her own ability and discover her weaknesses and strengths.

c. To develop independence and self-reliance.

d. To discover health and social needs through direct contact with patients and families and develop skill in helping families to meet these needs.

2. Method

a. Select case with regard for student's ability, needs and special interest, always with consideration for organization responsibility to the patient and community. Place emphasis first upon continuity of service and family health work. Experience in varied home situations is desirable and is much more important than varied nursing procedures. Assign cases first which are known to the agency, on which there is a family record and for which students may be prepared most completely, thus decreasing the unfamiliar element. Use cases which have been demonstrated to student only when this is acceptable to her and to the patient. When she has shown competence with known cases, she should be given new ones. Most students are ready for new cases by the third week. Antepartum work should be started as early as possible. Participation visits may be made in the second week but most students will not be ready for antepartum visits alone before the fourth week.

b. Pre-visit Preparation and Conference. For known case give student the case and family record to read. For new case give all information available. Ask her to study related manual material and plan her visit and her travel. Be sure that she understands clearly what she is expected to do, how it may be necessary to change her plan, and where she may call for help if she needs it. Have her tell you what she will do. Do not be satisfied with telling her.

c. Post-visit Conference

(1) Preparation. Have student complete recording of visit, including plan for next visit; look up material to be used in teaching patient; try to find answers to both patient's and her own questions.

(2) Conference. Listen to student's discussion of her visit. Review her recording. Help her to differentiate between important and unimportant factors and to make a definite and specific plan for her next visit, giving adequate consideration to the possible need to alter the plan. Teach her to analyze cases with consideration for—

a. The felt needs of the family
b. The needs as recognized by the nurse
c. The family plan for solution of their own problems
d. The nurse's plan for assisting the family
e. Progress made in carrying plan through
f. Apparent results of work done.

D. Student Visits with Supervision. The field teacher is responsible for field supervision with help as necessary from her supervisor or educational director. Supervision should be given on all new cases not later than the third visit. When this is not possible, this visit should be made by the field teacher or an experienced staff nurse. This close contact with all cases should continue until supervisor is sure of nurse's judgment. A mismanaged student case is a reflection on the supervision, not the student. Supervisory visits should be planned with consideration for the needs of the case and the student. The number of visits will vary with the student's ability and the

complexity of situations encountered. Generally, students should be supervised in at least two homes each week.

1. Purpose: (a) to insure satisfactory service to patients (b) to discover student's needs and give her necessary help.

2. Method

a. Preparation and Pre-visit Conference. Study student's record and discuss her plan for visit. Try to anticipate possible difficulties and plan to eliminate them. Ask her how she wants you to participate. Make it clear to her that she is to take the initiative and suggest means by which you can get together on a change of plan if this is necessary. Be sure that she knows the nursing technique involved and realizes that you are not making the visit to check on her procedure, since this can be done in the office.

b. Visit. Usually it is best to be quite passive and not to appear to observe the student closely as this may confuse her or disturb the patient. Give help as requested. If student seems ill at ease, busy yourself, if she approves, with some necessary part of the work. Try to keep her relationships easy and do what seems most likely to keep student self-confident. Often it is best to do nothing at all. On rare occasions it may be necessary for field teacher to actually take over the visit in the interest of satisfactory service to patient. This can almost invariably be avoided by adequate preparation for the visit. On leaving the home student will often request an immediate evaluation of her work. This should be postponed until field teacher has prepared for it, but a reassuring remark should be made.

c. Post-visit Conference. Field supervision has no value as an educational tool unless it is followed very soon by a well planned interview.

(1) Preparation. Fill out field supervisory report. Seek necessary help in interpreting student's behavior and determining your objectives for the conference. Formulate definite, specific, constructive suggestions to offer. Search for all commendable aspects of visit. Have student prepare for conference by writing up record and planning for next visit.

(2) Conference. Encourage student to take the lead in the discussion and listen to what she says. If she concentrates her attention on mechanical procedures give her help and satisfaction on this level. Commend her for good work and for progress. Then help her to consider the patient in relation to the whole situation, the health and welfare of the whole family, not with the idea that she has failed if she has not recognized significant factors, but in an attempt to help her develop insight and understanding.

Note: If a nurse does poor work when supervised it may be best to pass over it lightly and give her more opportunity for field participation and return demonstrations in the office, concentrating on one type of call until she feels secure. We assume that we should not teach basic skills but where this is necessary, classroom facilities should be used for practice of unfamiliar techniques, and this should precede field visits alone rather than follow field supervision.

E. Record Work. The record should play an important part in every case conference and in every conference preceding or following field supervision.

1. Purpose: to teach student—

a. The value of records and help her to understand the use made of information acquired.

b. To use information acquired by others in her early plans for cases.

c. To secure necessary information easily, maintaining a pleasant contact with patients in the process, using conversational methods as much as possible.

d. To analyze and interpret information, select pertinent material and record it graphically so that significant factors are apparent to anyone reading the record.

2. Method: teach student to do the following things—

a. Read and discuss all records on cases demonstrated or assigned to her. This will familiarize her with record forms and their use. She will recognize their value as a tool in her work if she learns to plan her approach to the family and her objectives for her visit from information acquired by others. Occasionally you may wish to discover what the student sees for herself in a known case and may withhold the family record until she has made a visit or two and written up her report.

b. When a new case is assigned to her, to select the necessary record forms,

study information secured by registrar, study forms to see what other information is necessary.

c. To write up her visit soon after it is made, using progress notes for narrative recording. She should write narrative accounts of her visits in detail to begin with, recording patient's condition, teaching, *et cetera*, specifically, thus revealing her recognition of symptoms and her evaluation of significant and insignificant factors. These narrative accounts should be written soon after each visit and before a return visit is made to a family.

d. To summarize important points concisely following each narration.

e. To summarize periodically as required by each case and transfer pertinent notations to the family record.

Note: Nurses who write with difficulty should learn to consider narrative recording and summarizing as homework exercise in rhetoric. Those who write concisely will need to summarize less frequently. As soon as their work warrants it they may be permitted to use the family summary sheets directly for their early case analysis, plans, and summary of work done.

F. Contacts with Physicians and Social Agencies. Students should make or participate in the making of all contacts necessary in connection with their cases. Those able to make these contacts themselves should be permitted to do so after discussion of the responsibility involved and a demonstration of the procedure to be followed. Early telephone calls should be made under supervision. Teach student to take patient's record, a pencil and pad and an outline of points to be covered to the phone or conference room, and to write down immediately all recommendations made or orders given; these to be recorded later in the proper place. When desirable for any reason, the field teacher should make the telephone call or accompany student on visits to other agencies or physicians, permitting her to take the initiative or bringing her into the discussion as she is able to participate.

G. Substation and Staff Meetings should be attended by students.

H. Field Trips. Because the student period is short and the program crowded, field trips as such are not included in the regular schedule. If students are interested in visiting particular agencies, arrangements may be made for them to do so whenever such experience will have value to them. Discuss plans with educational director.

I. Experience and Evaluation Reports. (See Substation Manual Section on Evaluation.) Responsibility for evaluation is carried jointly by the student, the field teacher, the supervisor, the educational director and the course or school director. The student keeps her own experience report but the field teacher must check it frequently for completeness and accuracy and to see that student is getting essential experiences. Problems must be discussed with the educational director early and reported by her to the home school in time to make any necessary adjustments. Weekly reports must be sent to the educational director on all students who are performing on less than a "C" level. Final reports must be written and discussed with the educational director before the student has her final conference with her field teacher.

THE AMERICAN JOURNAL OF NURSING FOR JULY

Redeployment of Nurses in the ETO
The NNCWS and V-E Day . . . Elmira B. Wickenden, R.N.
Progress in the Care of Premature Infants . . . Ethel C. Dunham, M.D.
The Income Tax and Nurses' Uniforms
What a Nursery School Can Teach You . . . Agnes Inglis
The Nurse in Physical Medicine . . . George Morris Piersol, M.D.
Intratracheal Suctioning . . . J. Karl Poppe, M.D., and Ruby B. James, R.N.
Traumatic Genito-Urinary Injuries . . . Gershom J. Thompson, (MC) USNR
The Preparation of Counselors . . . Frances Oralind Triggs, Ph.D.

Learning How to Be Supervised

By MARION SHEEHAN, R.N.

IN NOVEMBER 1943 the Visiting Nurse Association of Albany, New York, began a program of senior staff experience. The plan of the program followed one which has been offered for several years by various agencies and which was described in detail in PUBLIC HEALTH NURSING in March 1939.*

This experience was made available to those staff nurses who had "done good staff work, given evidence of teaching ability, possessed knowledge of the districts and who had had postgraduate public health work." It was arranged that each nurse thus qualified who requested the opportunity for this training would work with the supervisor in the student program for four months. The training consists of:

1. Planning with the supervisor each week's specific program of observation, classes, conferences and demonstrations.
2. Supervision of four students. Home visits with each are followed by written reports and conferences.
3. Setting up for classes and demonstrations.
4. Checking records, daily reports and experience sheets.
5. Assisting with final reports and conferences, grading, et cetera.

Albany VNA affiliating students come on an eight-weeks' basis; therefore, the four-months' senior staff work was planned in two periods to cover two groups of students. The senior staff nurse attends all classes, demonstrations and field trips. In her second eight weeks she prepares and teaches two classes of her own choosing.

Specifically, the senior staff nurse works with students, but for her own benefit also very closely observes daily such activities as call receiving, admission and discharge of cases, insurance writing, work distribution and handling of daily work slips, reports for statistics, et cetera. This alone makes a staff nurse more careful of detail and appreciative of accuracy in all phases of her work.

The main object of senior staff work is to discover future supervisory material. I feel that while this is true its greatest immediate value is the making of better staff nurses. It is a process of learning supervision and most especially of learning how to be supervised. The old fashioned idea of supervision as directing and critical overseeing of the nurse's work is apparently still held by a great number of nurses today. They are unable to see, as Violet Hodgson puts it, "the orders and commands of past years become the instruction and leadership of today."

We can see and appreciate in our supervisors such personal qualities as interest, cooperation, kindness and fairness. We recognize that they are emotionally stable and possess initiative and judgment based on common sense and scientific knowledge. Unless, however, we go further and seek to understand the principles upon which these people so qualified base their daily work with us, how can we hope to respond to their guidance with any measure of success?

As G. C. Kyte says, "the ultimate goal for each supervisor is the maximum development of each nurse into the most competent person professionally that she is capable of becoming." Personal and

Miss Sheehan is acting junior supervisor of the Visiting Nurse Association, Albany, New York.

*Grover, Mable E. "Supervisory Experience for Staff Nurses." PUBLIC HEALTH NURSING, March 1939, p. 156.

professional growth is certainly an aim for every nurse and just as certainly it is not attained without instruction and leadership. Our instructors and leaders are our supervisors. We must not expect them to tell us what to do but rather to help us find the way to do. The teaching methods and principles that our supervisors are trying to use in their work with us are the very ones we use every day with our families and are based on the same qualities in people, namely, native intelligence, attitudes, individual interests and previous learning.

With this in mind we can respond more intelligently to supervision. When it becomes necessary to do new things, or old things in a new way, and our supervisors can present the changing situations with due consideration of each nurse's individual differences, cooperation and interest can be obtained from all.

We must see that we have within ourselves reciprocal stores of cooperation, friendliness, and understanding. In general we must help supervisors to help us as individuals and to know our needs through analysis and evaluation. When this has been done we will have helped our leader know her group. She can then foster a working together for the common improvement of all, resulting in a better service to the community.

As already said, the period of senior staff work brings these points forcibly to mind because it is a time of learning by doing. It is a period for the growth of understanding that comes from working directly with students and observing what they must do to help the supervisor help them. It is a training that ever after affects the nurse and her own relationships with supervision and as such would benefit every staff nurse.

NNCWS To Carry on Urgent Projects

(Continued from page 334)

financed by the General Education Board, and advocated that some other agency than the Council accept sponsorship for the work before the Council closes its doors. One of the high points in the field work done by the Negro consultants was a conference with educators from all over the South, held at Dillard University December 1 and 2, with a follow up in the form of definite recommendations to Dr. Thomas Parran, USPHS, and cursory surveys of nursing facilities in different localities by college students.

Another was a visit to Oklahoma at the request of the president of Langston University, State College for Negroes, to make a preliminary survey of possibilities for developing nursing education for Negro women in Oklahoma. The consultant spoke before the appropriations committee of the State Legislature in the presence of the Governor, urging consideration of development of nursing education facilities. The Legislature has since appropriated $100,000 for this purpose.

One of the Council's Negro consultants projected the idea of developing the collegiate school of nursing which opened February 1, 1944 at Hampton Institute, Virginia. The nursing schools at Tuskegee Institute, Alabama, and Freedmen's Hospital, Washington, D. C., have been reorganized with Council assistance.

Mrs. Wickenden reviewed the student nurse recruitment that has been carried on by the Council under contract with the USPHS. "Box 88" received and answered 236,555 queries during 1944. An extensive college counseling program in nursing was carried on jointly for the second year.

The Council's National Classification Committee, working under the Procurement and Assignment Service for Nurses, as of May 15 had classified 8,448 nurses employed on a national or regional basis.

"No citizens more richly deserve the best of nursing care than do the war veterans, and the profession has an inescapable responsibility to do anything needed to provide it," declared Mrs. Wickenden, in urging that the Council's committee on recruitment of nurses for the Veterans Administration keep intensively on the job. This committee arranged, with the cooperation of the Veterans Administration, that a group of nurses should visit different types of facilities to study nursing procedures and conditions under which nurses work. The report of this study group is not yet ready.

Reporting on public information activities that have accompanied all projects, Mrs. Wickenden said, "The recent furore over a potential draft of nurses has demonstrated, first, the enormous potential public interest in a profession that serves human needs as vitally as nurses do and, second, how many people are not yet adequately informed about nursing."

Reviews and Book Notes

OCCUPATIONAL ACCIDENT PREVENTION

By Harry H. Judson and James M. Brown. 234 pp. John Wiley and Sons, Inc., New York, 1944. $2.75.

The authors have presented in simple, readable style a reference manual which will be very helpful to industrial nurses, safety engineers, supervisory employees, foremen, and others vitally interested in an accident prevention program in industry.

Accident prevention is divided into three main divisions as follows: improvement of work procedures, improvement of the plant and equipment, and safety activities. In each division, consideration is given to the part played by management, supervisory staff, and all other employees. The importance of management's interest in accident prevention is stressed for the successful program as it not only yields dividends in the prevention of accidents, but economic returns as well.

There is a list of films, including slide films with sound, that is very comprehensive and up to date, and which should fill the great demand for such material at this time.

MARY ALTON, R.N.
Lansing, Mich.

MICROBIOLOGY LABORATORY MANUAL

By Ethel J. Odegard, R.N., A.B., M.A. 183 pp. The C. V. Mosby Company, St. Louis, 1944. $2.50.

This laboratory manual and work book in microbiology is practical and purposeful in its emphasis. Its arrangement follows a simple unit plan that could be adapted easily to the average nursing school course in the subject. The exercises have been carefully arranged; the directions are clearly stated; and the author has maintained a simplicity throughout that would seem to make the manual adaptable to the resources at hand in the nursing school laboratory. A study of the exercises also shows that the planner has been faithful in meeting the objectives as outlined in the preface, which are briefly: "to provide the student with an understanding of what bacteria are; to correlate the principles of asepsis with medical and surgical asepsis as used in hospital, clinic, and home; to give meaning to the subject matter discussed in the lectures; and to teach the student . . . to make independent observations."

In arranging the units, that on public health and sanitation includes two subjects, namely, water analysis and sanitary control of milk and other foods. While this unit in itself has been well handled, one wonders whether the subject of prevention and control might not have achieved a broader emphasis had the unit on destruction of microorganisms and the material on disease resistance been included in its scope.

In the exercise on acid-fast staining, this reviewer and teacher of inexperienced laboratory workers feels that the suggestion of the use of a nonpathogenic mycobacterium might perhaps be more suitable to the skills and techniques of the workers than the tuberculosis sputum called for in the exercise.

The pages of this manual are of the looseleaf variety, the type is clear, and the spacing is good. There are a number of helpful diagrams, while frequent blank pages leave room for notations. Each unit is followed by a set of essay-type questions and a summary outline for the student to use in evaluation of her work in the unit. It is to be regretted that no index is included at the back of the manual. There is no doubt that this manual is workable and should fill a need, especially in these crowded days when it is difficult to find time to prepare individual laboratory plans.

MARGARET B. ALLEN, R.N.
Orange, N. J.

CASUALTY WORK FOR ADVANCED FIRST-AID STUDENTS

By A. W. MacQuarrie, M.B., Ch.B. (Edin.) 231 pp. E. and S. Livingstone Ltd., 16-17 Teviot Place, Edinburgh, 1944. Imported by Peter Reilly Company, 133 North 13 Street, Philadelphia, 1944. $1.80.

Out of the demand for more information concerning first aid came this pocket-size volume. It is a supplement to the usual first-aid manuals.

It was written for English first aiders who were being trained to analyze quickly a patient's symptoms so that no time would be lost in the referral to medical care or hospital, as the case demanded. The rapid handling of the injured made it possible for the workers to take care of an increased number of casualties and was responsible, therefore, for saving many lives. Immediate control of hemorrhage, immobilization of badly damaged tissues, and rapid delivery to the surgeons has been stressed throughout.

The subjects of shock, asphyxia and wounds are thoroughly covered. There has been no repetition of basic material, however, where it was felt that the first aider was already well trained.

Transportation is also very important as there are many new methods which have been devised and used to good advantage during the "Blitz." It is well for the first aider to know these methods so that further injuries may be prevented.

This is an interesting reference book especially for those who need to review first aid and will prove of much help to the nurse in industry.

DORIS A. RAMSEY, R.N.
Berlin, N. H.

ELIMINATION DIETS AND THE PATIENT'S ALLERGIES

By Albert H. Rowe, M.D. 256 pp. Lea and Febiger, Philadelphia, second edition revised, 1944. $3.50.

This book is written mainly for the use of the physician. The first part is concerned with the causes of clinical allergies and suggests methods for their diagnosis and control. Although many causative agents are discussed, primary consideration is given to foods which cause allergic reactions.

The second part of this book gives a number of elimination diets to fit a variety of food-allergy conditions. These diets are accompanied by sample menus and practical recipes. The author has been careful to plan balanced meals so that the patient will receive all the food elements required for good nutrition. The appendix includes lists of ingredients found in various commercial foods, as well as lists of household materials and their possible allergens. The reader who is interested in the practical application of the newer concepts of allergy treatment to dietary practice would find this book a valuable aid.

NELLE M. SAILOR
Boston, Mass.

THE PRINCIPLES AND PRACTICE OF INDUSTRIAL MEDICINE

Edited by Fred J. Wampler, M.D. 579 pp. The Williams and Wilkins Company, Baltimore, 1943. $6.

Wampler's book was originally intended for the use of practicing physicians and medical students who are entering the field of industrial medicine. Thirty-three recognized specialists from the fields of education, industrial medicine, nursing, and engineering have participated in the preparation of a book which is especially well organized and authoritative. Health conditions resulting from hazards in the industrial environment, methods of protection and prevention, and the rehabilitation of the affected workers are discussed at length.

The chapter on nursing was apparently submitted some time before the book was published and hence does not include some of the most recent developments, but the content is informative.

The language is easy to read and the book should be a real asset to the nurse in understanding the more technical aspects of industrial health. It should also help her to correlate her activities with those of other welfare personnel so that provisions may be made for maximum health protection of the worker.

ELEANOR BAILEY, R.N.
New York, N. Y.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

TUBERCULOSIS

CLINICAL EVALUATION OF THE REHABILITATION OF THE TUBERCULOUS: EXPERIENCE AT ALTRO WORK SHOPS, 1915-1939. By Louis E. Siltzbach, M.D. National Tuberculosis Association, 1790 Broadway, New York 19, N. Y., 1944. 70 pp. Paper-bound: 50 cents; Cloth-bound: $1.

D DAY AGAINST TB. By J. C. Furnas. *Ladies' Home Journal,* April 1945, page 39. The Curtis Publishing Company, Independence Square, Philadelphia 5, Pa. Single copy: 15 cents.

MASS RADIOGRAPHY OF THE CHEST. By Herman E. Hilleboe, M.D., and Russell H. Morgan, M.D. The Year Book Publishers, Inc., Chicago, Ill., 1945. 288 pp. $3.50.

NATIONAL TUBERCULOSIS ASSOCIATION—TRANSACTIONS OF THE FORTIETH ANNUAL MEETING, MAY 9-12, 1944. The Association, 1790 Broadway, New York 19, N. Y., 1944. $3.

Papers given at the Conference on Tuberculosis Nursing are very timely: "Affiliations in Nursing in Tuberculosis," by Esta H. McNett, R.N.; "A Course in Tuberculosis Nursing for Graduate Public Health Students," by Grace M. Longhurst, R.N.; "War Emphases in Tuberculosis Nursing," by Mrs. Louise Lincoln, R.N.

GENERAL

BREAST CANCER. Prepared by the U. S. Public Health Service, National Cancer Institute, National Institute of Health, Bethesda 14, Md., 1945. 9 pp. Free.

A new educational pamphlet, limited quantities of which are available free to public health organizations.

BUILDING A POPULAR MOVEMENT: A CASE STUDY OF THE PUBLIC RELATIONS OF THE BOY SCOUTS OF AMERICA. By Harold P. Levy. Russell Sage Foundation, New York, N. Y., 1944. 165 pp. $1.25.

Second of the studies in public relations put out by the Foundation, it gives an excellent picture of a national movement.

HEALTH CARE FOR AMERICANS. By C.-E. A. Winslow. Public Affairs Pamphlet No. 104. Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York 20, N. Y., 1945. 32 pp. 10 cents.

A straightforward, clear presentation of the need for adopting national health measures now to take care of the serious lack of hospitals, health centers, and laboratories in rural sections and cities where sudden increases in population have occurred.

HOW AND WHERE TO COLLECT SOCIAL SECURITY. Prepared by the Industrial Relations Institute. Commodity Research Bureau, Inc., 82 Beaver Street, New York 5, N. Y., 1945. 32 pp. 15 cents.

Based on 1945 study of the functioning of the Social Security Act, taking into consideration the up-to-date official interpretations.

HUMAN ANATOMY AND PHYSIOLOGY. By Nellie D. Millard, R.N., and Barry G. King, Ph.D. W. B. Saunders Company, Philadelphia, second edition, 1945. 514 pp. $3.

A good reference book for the individual, containing excellent illustrations and stressing function—an emphasis different from that of most anatomy books. Also has a 100-page Outline for Teachers as a supplement.

LIVING WITH A DAMAGED HEART. By Charles A. Poindexter, M.D. *Woman's Home Companion,* June 1945, page 36. The Crowell-Collier Publishing Company, 250 Park Avenue, New York, N. Y. Single copy: 15 cents.

PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK—SELECTED PAPERS, SEVENTY-FIRST ANNUAL MEETING, CLEVELAND, OHIO, MAY 21-27, 1944. Columbia University Press, New York, 1944. 492 pp.

THE PUBLIC HEALTH NURSE TODAY. By Winston H. Tucker, Ph.D., M.D. *The Illinois Medical Journal,* January 1945, page 31. Managing Editor, 30 North Michigan Avenue, Chicago 2, Ill. Single copy: 50 cents. (Reprinted).

THE TREK FROM YESTERDAY: A HISTORY OF ORGANIZED NURSING IN MINNEAPOLIS, 1883-1936. By Bertha Estelle Merrill, R.N. Minneapolis Nurses Association, 1100 Donaldson Building, Minneapolis 2, Minn. 96 pp. $2.

How the Minnesota SOPHN began and much other information about early public health nursing.

HEALTH AND WELFARE PLANNING IN THE SMALLER COMMUNITY. Published by Community Chests and Councils, Inc., 155 East 44 Street, New York 17, N. Y., 1945. 27 pp. 25 cents.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

UNIFORMS AND SYMBOLS

National interpretation of public health nursing is definitely handicapped by the wide difference in names of organizations employing public health nurses, and by the lack of a uniform or symbol which readily identifies the public health nurse to the public. This lack of a symbol was no small obstacle in national publicity for Public Health Nursing Day last January. How to picture the public health nurse when one city knew her in a brown uniform, another in a blue uniform? And in no two cities was she identified by the same symbol or even the same hat! No wonder one of the largest advertising agencies said, "The first step in promoting greater recognition of the work of the public health nurse would certainly be the establishment of at least a popular symbol on an armband."

With this advice in mind, the NOPHN Board and Committee Members Section has appointed a committee of nurses and non-nurses to explore the possibility of establishing such a symbol. Their report is eagerly anticipated by agencies and nurses alike. Before they begin work they will want in front of them practical suggestions from everybody who is interested —suggestions on both uniforms and symbols.

But the question of what uniform is not less important than how to wear one. Nurses on the home front—being women —have always been vexed by uniform questions and most agencies have their uniform committees. The Nursing Division of the Los Angeles City Health Department, too, has such a one. The report of this committee, however, makes unusually good reading. The situation they faced was similar to that confronting many a nursing agency. This was their problem:

On the Los Angeles staff are the lean, the fat, the short, the tall—the young nurse just out of training and the veteran nurse of several years' experience. Each one is representative of the nursing staff and each one is desirous of looking her best.

"We sat around a table and discussed the pros and cons of our complete uniform," states the Committee in an illustrated report, "and how we could help inspire ourselves, and others, to appear our best at all times. As nurses of the Los Angeles City Health Department, we are important representatives of our department, our nursing profession, and last but not least, of the citizens of our city."

With the motto, "Oh, wad the power the giftie gie us to see oursils as ithers see us!" the Committee recommended:

At the head—where our brains are—we wear navy blue, brown, or black, and/or white panamas. Definitely no deviation.

For our little girls who must grow up—no hair ribbons. A narrow black, plain band, if necessary for good grooming, may be worn.

No earrings. They are not our uniform.

We like the sweater girl idea. Uplift brassieres make shapely "figgers."

You will want a firm foundation for that glamour girl appearance which streamlines the "tummy" and hips, and also holds up our long hosiery.

No bobby socks or bare legs.

White, black, blue, or brown shoes with matching accessories. White shoes are to be white. Dark shoes may be worn with white hats whenever white shoes are impractical.

Beige salyna cloth made like Butterick Pattern 2085, worn with white uniform collar and white pearl buttons. No set-in belts. Summer coat made after pattern (Vogue) 9372. Jacket pattern (Vogue) 9453. Winter coats are of dark, durable material. If not our regular uniform coat, the directors' approval is needed.

To wear or not to wear jewelry is up to the discretion of the nurse and the type of district she has. No costume jewelry is needed to dazzle our coworkers and patients. Our personalities and knowledge will do this for us.

The Uniform Committee was composed of: Margaret Faye Allen, chairman; Mrs. Jerry C. Caveney; B. Louise

Chase; Mrs. Ann E. Cawthorn; Elsie M. Brandt. Gertrude Ward illustrated the report.

HAZEL HIGBEE TO NOPHN

The services of Hazel Higbee, assistant director, public health nursing program of study, Medical College of Virginia School of Nursing, Richmond, have been secured for the months of August, September, and October to assist Mary C. Connor, NOPHN associate director in education. Her principal assignment will be the analysis and summary of data secured from the annual reports for the academic year 1944-1945 submitted by the 31 universities with approved programs of study. Miss Higbee received her basic nursing education at Battle Creek Sanatorium and Hospital Training School for Nurses, Michigan, and her B.S. degree in nursing at Western Reserve University, Cleveland, Ohio. Her previous positions include: instructor of public health nursing, Western Reserve University, Cleveland; associate consultant in public health nursing, U. S. Public Health Service; assistant professor in public health nursing, Western Reserve University, Cleveland.

NOPHN FIELD SCHEDULE

Ruth Fisher will be in Johnstown, Pa., from July 16 to 19, to make a survey of public health nursing. Dorothy Rusby is including in her western trip a visit in July to Phoenix, Ariz.

June field trips for NOPHN staff members, in addition to those listed in the June issue of the magazine, included the following: Alberta B. Wilson attended sessions of the Legislative Study Group for Health and Physical Fitness in Washington, D. C. Mary C. Connor participated in a meeting of the Steering Committee for the Commission on Education in Washington. Ruth Fisher attended a meeting of the nursing staff of the Eastern Area of the Red Cross in Alexandria, Va. Ruth Scott gave advisory service on industrial nursing in Philadelphia, Pa. Mable Grover of the AWCS staff visited Bay City, Saginaw, Flint, and Pontiac, Mich. Louise L. Cady held tuberculosis institutes in New Orleans, Lafayette, Alexandria, Shreveport, and Monroe, La. Jessie L. Stevenson, as president of the American Physiotherapy Association, attended that organization's Annual Meeting at Bear Mountain, N. Y.

NEW CONDENSED GUIDE

The Joint Committee on Community Nursing Service (representing the NOPHN, ANA, and NLNE and recently expanded to include representatives from the National Association of Colored Graduate Nurses, Association of Collegiate Schools of Nursing, and National Association of Practical Nurse Education) has compiled a brief appraisal form, "A Guide to Determine Distribution and Needs of Civilian Nursing Service." This offers a much needed means of quickly gaining an overall glimpse of the nurse needs in the community. It is a condensation of the "Schedule for a Survey of Community Nursing Service" which was originally prepared in 1939 and revised in 1944.

The Joint Committee has turned the new Guide over to the National Nursing Council for War Service for distribution, and copies have already been sent to state nursing councils, as well as to those local groups who have requested it. Copies are available from the Council, 1790 Broadway, New York 19, N. Y., which is offering it in the hope that each community will undertake an analysis of its immediate needs, if it has not already done so.

CRUTCH WALKING SLIDES READY

New slides on crutch walking are now available on loan from the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, N. Y. Included in the slides, which are accompanied by a detailed script, are bed exercises in the preparation of the patient to walk and a demonstration of four different gaits.

ARE YOU CHANGING YOUR ADDRESS?

Subscribers changing their addresses should notify the NOPHN office at 1790 Broadway, New York 19, N. Y. *six weeks* before the change is to take effect. Both *old* and *new* addresses must be given.

NEWS AND VIEWS

Highlights on Wartime Nursing

PLANNING FOR FUTURE NURSING

The National Planning Committee of the National Nursing Council for War Service is making excellent progress in rounding out its composite program for nationwide study and action aimed at providing "nursing service at a high level of competence for all the people." Work in those areas demanding immediate action is not to be delayed until the entire program is agreed upon. The program will, indeed, more or less continually be in process of evolution, as initial studies and fact-finding activities point to adjustments.

Priority, the Planning Committee has agreed, should be given to the following projects, on several of which preliminary work is already under way, either under the aegis of the National Nursing Planning Committee itself or one of the member agencies:

A study of nursing education, to determine the most effective type of organization, administration, and financial support of schools of nursing. As one part of such a study, suitable definitions for professional and practical nurses are to be determined, and controlled experiments carried on to establish a satisfactory proportion of hours' care from each type of nurse in different situations.

Determination of standards for satisfactory employment conditions, through development of sound personnel practices and policies.

Study of existing resources in numbers and types of nurses, and facilities for nursing service, and study of present and future nursing needs.

Study and development of community nursing councils on state and local levels. Here the war experience of nursing councils, with their active representation of all community groups, would be expected to stimulate community interest in the provision of good nursing service.

Other phases of the work outlined thus far, and also in many cases already in progress, include the following:

Development of placement services that will be satisfactory to prospective employers and employees—for immediate placement needs, for the transition period from war to peace, and also on a permanent basis for the future.

Revision and construction of curricula for existing schools and programs, or those to be established in the future.

Establishment of desirable standards and effective methods for accrediting schools of nursing and programs of nursing education.

Establishment of a system of educational counseling for individuals, agencies and organizations. Special attention would be paid to the development of measurement and testing services, which can be utilized in all other areas of investigation, particularly in connection with placement.

Development, through studies and demonstration, of effective methods of supplying nursing service on a community level, with flexible provision for local adaptation.

Determination of standards in relation to every phase of nursing service. This is a professional responsibility and would be developed out of all other studies.

Development of a recruitment program conducted by the profession to maintain a desired inflow of students into schools for both professional and practical nurses.

Establishment of a broad program of information and public relations which will interpret to the public what good nursing service means to the people and the responsibility the public must assume to assure it.

New chairman of the Planning Committee is Pearl McIver, chief of the Office of Public Health Nursing, Bureau of States Services, U. S. Public Health Service, and chairman of the Council of Federal Nursing Services. She takes the place held for a year by Marion W. Sheahan, NOPHN president, who resigned in May because of the pressure of other duties. Miss Sheahan remains a member of the executive committee.

NEW STATUS FOR VETERANS NURSES

Beginning July 1, 1945, nurses in the Veterans Administration service assumed a professional status on a parity with the nurses of the

Army and Navy Nurse Corps and the U. S. Public Health Service by virtue of a recent reclassification order. The new order brings about pay increases—making the salary range extend from $2,000 to $4,600, plus overtime—a policy of rotation from isolated stations after two years of service, and an advanced educational program. The educational program includes postgraduate courses at government expense, together with leaves of absence without pay for those nurses desirous of obtaining college degrees. Under this policy, seniority is retained by nurses during the time they are in schools.

The use of senior cadet nurses by Veterans Administration Facilities will be continued, and the establishment of in-service programs of training in amputation and chest surgery centers and cancer clinics, together with 27 hospitals designated for special treatment of spinal cord injuries, will result in a broad opportunity for nurses to improve their knowledge.

The reclassification now in effect is expected to help in the recruitment of nurses to meet the demand for 2,000 nurses needed immediately in the Veterans Administration Facilities.

CADET CORPS TWO YEARS OLD

The U. S. Cadet Nurse Corps observed its second birthday July 1. National recognition of their achievements is the bright birthday tribute to cadet nurses, states *Cadet Nurse Corps News,* June 1945. Although their average age is only 19, their splendid record includes: the releasing of graduate nurses for military service, maintaining essential nursing service in civilian hospitals; and providing 80 percent of the care given to patients in hospitals with schools of nursing.

Under the terms of the Nurse Training Act, which established the Corps, the program will continue to the termination of hostilities and cadet nurses enrolled 90 days prior to that time may complete their nurse education under the Federal scholarship plan. The quota of new student nurses to be recruited by June 30, 1946, has been set at 60,000.

SUMMER ENROLLEES

As a guide in counselling recent graduates, nurse directors of postgraduate programs of study have been advised by Lucile Petry, director, Division of Nurse Education, USPHS, that graduate nurses enrolling in intersessions and summer sessions need not be classified by Procurement and Assignment Service as essential for postgraduate study. A limited number of carefully selected 1944 and 1945 graduates with exceptional ability should be considered for enrollment.

EXHIBIT OF MEAT SUBSTITUTES

As a service to local housewives, a practical exhibit of foods which can be used adequately to replace meat opened June 15 for a month's appearance at the Brooklyn Museum under the combined auspices of the nutrition divisions of the Department of Health, the VNA of Brooklyn, and the Brooklyn Red Cross. The exhibit features information on meat substitutes—(1) telling what meat contains, why the protein of meat is needed, and what foods supply this in lieu of meat—cereals, legumes, milk, cheese, eggs, fish, and nuts and (2) explaining the nutritive value of these different foods and how to bring them up to standard in combination with other foods. A leaflet containing recipes and menus for meals that are "good to look at, good to eat, and good nutrition" is distributed to every visitor to the exhibit.

According to Edith M. Shapcott, nutrition consultant of the VNA, although nutritionists have combined their activities since the war began to help the home front meet its food problems, the real stringency is here today and it is necessary as a public health measure for nutrition experts to redouble their efforts.

From Far and Near

● Smith College, Northampton, Massachusetts, awarded an honorary LL.D. degree to Mary Beard, retired director of the American Red Cross Nursing Service, at its 67th commencement exercises recently. She was the only nurse among the five outstanding women who were awarded honorary degrees by the college. Miss Beard is a member of the NOPHN Board of Directors.

● Lucile Petry, director of the Division of Nurse Education, USPHS, recently received honorary degrees from Adelphi College, Garden City, New York, and the University of Syracuse,

Syracuse, New York. The degree of Doctor of Humane Letters was conferred upon Miss Petry by Adelphi College on June 6. At the ceremony dedicating the new School of Nursing building at Syracuse University June 7, Miss Petry was awarded the degree of Doctor of Laws.

In presenting the honorary degree of Doctor of Laws, Chancellor William P. Tolley of the University of Syracuse cited her for her "work on program of far reaching significance for the health of the Nation, striving always with courage and clear vision born of a dauntless belief in the social importance of the nurse . . . and laboring to bring about the highest standard in the care of the sick, in public health and in nursing education."

Obtaining Derris—A news story in the January 1945 Magazine (p. 47) on the control of head lice by use of derris powder brought many inquiries as to how the latter might be obtained. Helen Louise Trembley, author of the article abstracted, has advised as follows:

"Derris powder is sold under the name of 'derris' and old stock is sometimes found on the shelves of local stores. However, much of the present available supply is allocated by the WPB to certain restricted agricultural and veterinary uses. It is possible that local or state WPB boards will release the comparatively small amount necessary by adding this need to the list of approved uses, or by considering this an experimental project."

England's Health and Birth Rate Good in 1944—Health of the English people, despite five years of war, continued to be favorable in 1944 and births reached their highest point since 1923, according to the *MLI Statistical Bulletin*, April 1945. Nearly 750,000 babies were born to English families last year, representing an increase of nearly 10 percent over 1943 and of more than 25 percent over the wartime low of 1941 and the depression low of 1933. In the last three years alone the increase of births over deaths in the civilian population was 610,000 and for the war period thus far well over 700,000. Infant mortality in 1944—about 46 per 1,000 live births—was the lowest in England's history, and represented a reduction of nearly 20 percent from the average for the three years preceding the outbreak of war. Maternal mortality rate in the first six months of 1944, latest figure available, was less than half the prewar figure. The civilian death rate, 11.9 per 1,000, was, with the exception of 1942, lower than for any other war year. While deaths from violence, especially those due to enemy action, increased sharply, the record for disease on the whole was very favorable. Mortality from tuberculosis continued to decline, probably to the lowest level in England's history, though an increase in the disease in the early years of the war caused some alarm. Mortality from the degenerative diseases of later life was below the average for the war years, despite the higher proportion of older persons in the population. The child health picture continued to be favorable. (See also Len Chaloner's article, page 335.) The decrease in diphtheria was most remarkable, particularly in view of the large increase in the child population during the war years.

Legal Considerations of Industrial Medical Records—In an article by T. V. McDavitt (*American Journal of Public Health*, June 1945, p. 568), the basic content of industrial records, minimum objectives and restrictions in their use are set forth.

Minimum aims of the records, which suggest also some of the functional uses to which they may be put, are stated as:

1. The serving of the direct interests of the employer, such as placement of the worker in his most useful capacity, and legitimate defenses to claims for compensation for alleged industry-incurred disabilities.

2. The protection of the health of the individual worker and the serving of his best interests.

3. The evaluation of facts and trends of importance to other workers in the plant.

4. The ascertainment of facts that can be utilized by the medical profession and by public health agencies in the promotion of the health of the public generally.

Basic content of the medical record should be: identification data, past medical and occupational history, physical findings from various examinations, personality appraisal, laboratory data, record of visits to dispensary, other medical history since employment, absenteeism record with causes, all correspondence regarding the employee.

Restrictions on the use of the industrial medical records stem from the degree to which the records are regarded as a confidential communication between the patient and the physician. To the extent the principle obtains that an employer can make only such use of those portions of the record as is consistent with the purposes for which the procedures were performed and in connection with the legitimate interests of that employment, the relationship seems to be one of quasi-confidential nature. It would seem, according to the author, that an employer has a threefold purpose in retention of the record: (1) in a confidential or quasi-

confidential capacity for the workman (2) as evidence of the care and attention his own agents or employees have rendered the workman and (3) for purposes related to the efficient and healthful conduct of his operations. Acceptance of these purposes leads to the theory that the employer can make no use of the records except in defending himself or in the direct interest of the employment. From the workman's point of view, he is entitled to privacy and the incidents of his illness should be restricted to the view of those acting in his interest. Limitation of the disclosure of the records to three situations—in connection with the employer's legitimate interest, on request of or with consent of the worker, or in the actual interest of the worker—seems to exclude their use as a basis for statistical study, clinical or other investigations. However, such use should be permitted if the individual records can be used and presented in such a way as not to reveal the identity of the particular employees. In connection with the demands of a worker for access to the records, consideration should be on the basis of whether there is good reason for denying him access. "Access might as well be granted for in any event if litigation occurs the production of those records in court or before some tribunal can be compelled." Also, where the employee's attending physician desires to see an industrial record, it would seem access should be granted, both (1) when the employee authorizes the employer to grant access and (2) even in the absence of employee authorization, on the theory that by placing himself under the physician's care he has authorized him to use such measures as are necessary to diagnose his condition and pursue the proper course of treatment.

Regional Increases in Tuberculosis—Data available from various parts of the country indicate a definite increase in the tuberculosis death rate in many north-central and northeastern industrial cities last year, with a normal decline in other parts of the country. The increase in Massachusetts has been largely among the older age groups with an excess among males. "In my opinion this increase is largely the result of breakdown among older men who are working beyond their strength," says Alton S. Pope, M.D., in the December 1944 *Massachusetts News Bulletin*. A larger number than usual of tuberculous patients are refusing sanatorium treatment. Others are leaving the sanatorium against advice to take jobs at the current high wages. Overcrowding due to the present housing shortage is probably of importance in the spread of tuberculosis, Dr. Pope says, "but there has so far been no increase in tuberculous meningitis and generalized tuberculosis in children such as occurred in England during the first two years of the war."

Health Experts and Medical Men to China—Thirty medical and health experts to train personnel in medical centers to be set up by the Chinese Government and the essential medical supplies to equip the training centers are to be sent to China through the United Nations Relief and Rehabilitation Administration, according to a recent announcement of its director, Herbert H. Lehman. Shipment of the supplies has already started, and UNRRA is now recruiting medical and public health experts—including surgeons, physicians, nurses, maternity and infant care and tuberculosis specialists, and other needed professional personnel. First to be sent to China will be the men with general medical experience. The specialists will follow later after the training programs are set up. The Chinese Government plans to establish training centers in Chungking and Chengtu early this summer and later in Kweiyang. Now after eight years of war, it is estimated that there is only one doctor for every 40,000 persons in China and one hospital bed for every 10,000 persons. Up to 40 percent of the hospitals have been destroyed or looted. China, it is estimated, will need to train roughly 35,000 technicians in the next four years to administer her medical relief program.

State Legislatures Consider Health Insurance—Numerous bills embodying compulsory health insurance provisions were considered in state legislatures in the first quarter of 1945. Bills to provide medical, nursing, laboratory, dental and hospital services were introduced in the states of California, Connecticut, Michigan, New Mexico, New York, and Wisconsin. Little success to date toward passage is reportable in any of these states, according to the *Journal of the AMA*, May 5, 1945—with most of the bills either dead, in committee and probably dead, or in committee and no other action to date. Bills to provide cash payments for sickness—so-called cash sickness insurance—were presented in the states of California, Colorado, Massachusetts, Minnesota, Montana, Nevada, and New Jersey. Bills to authorize the study of health insurance system were introduced in California, Connecticut, Maryland, and West Virginia—the California bill adopted in January, West Virginia in February. Three bills proposing constitutional amendments to direct enactment of so-called health service system were presented to the legislature in California.

Amputees Learn They May Resume Useful Roles in Society—Of 11,000 amputation cases that have been cared for in Army hospitals to date, almost 4,000 have been discharged to civilian life. Some of these soldiers, who were given the choice, wanted to remain in the service and have been assigned to assist in the training of other amputees.

The Army does everything possible to help these soldiers make their readjustment. It is not unusual for men with the loss of two arms or both legs to drive an automobile, ride horseback, use a typewriter, eat and dress without help, dance, and in general do almost everything they formerly did.

No serviceman has lost both arms and legs. Six amputees have lost three extremities; one part of four limbs as a result of freezing after an airplane crash.

Major General Norman T. Kirk, Surgeon General of the Army, stresses the fact that because these men are trained to lead a useful life before they are discharged from the Army, the public should be prepared to receive them as normal human beings who do not want any display of pity or sympathy but simply a chance to hold down a job commensurate with their ability and to assume their rightful places as useful members of society.

To assure amputees the best possible medical and surgical care, the Army has designated seven general hospitals as amputations centers. Each center has an orthopedic shop completely equipped to fit artificial limbs. Outstanding specialists handle the amputation cases in these centers, and to get the best results, the surgeon maintains a close liaison between the patient and the limb mechanic, the physical therapist, occupational therapist, and reconditioning officer.

Average time from the final operation until an amputee is fitted for his artificial limb is about two and one half months. From the time of injury until discharge is usually about eight months. Before any of these amputees are discharged, they must pass a series of performance tests which will show if they are ready to return to duty or to a civilian status.

N. Y. Health Plan Adds Visiting Nursing—Extension of its services to include home care by visiting nurses without additional charge was announced June 1 by Group Health Cooperative of New York City, first community medical insurance plan to include such benefits. The service, which will be obtainable at the discretion of the physician, will be available as long as experience remains favorable. In announcing the extension, Group Health stated it hoped it would show other plans all over the country the value and importance of visiting nurse service in helping doctors help their patients back to full health. Four ways in which the visiting nurse could be helpful to a subscriber are listed as: (1) *after* a surgical operation at the hospital (2) *after* surgical care at home or at the doctor's office (3) *after* medical care (non-surgical) at the hospital and (4) in maternity cases. The *New York Times*, reporting the addition, stated the public health nurse's inclusion in the plan is both good insurance practice and good medicine. "By carrying out the doctor's orders she keeps the bills down and hence the expense to which the Group Health Cooperative is put."

DDT and Preventive Medicine—DDT (dichloro-diphenyl-trichlorethane), a new and powerful insecticide, has become a potent factor in the field of preventive medicine since 1942 when the U. S. Department of Agriculture turned it over to the Army for mass experimentation to determine the extent of its effectiveness. Quoted in April 30, 1945 *Health News*, New York State Department of Health, U. S. Army General James S. Simmons said: " . . . the knowledge gained of this amazing chemical constitutes the most valuable single contribution of wartime medical research to the future health and welfare not only of this nation but of the world."

Some of the world's most feared diseases are exclusively insect-carried, and it has been determined that DDT is extremely effective in the extermination of most forms of insect life. There is a catch to this, however, since DDT is not particularly discriminating and proves deadly to beneficial and neutral species as well. A joint statement of policy by the U. S. Army and the U. S. Public Health Service explains their plans:

"DDT will be used for residual spray application to houses and other buildings for the purpose of killing adult mosquitoes before they have opportunity to transmit malaria. The long-lasting killing effect of DDT as a residual spray provides a highly effective means to prevent the spread of the malarial parasite. This method of use is safe and economical, and moreover, is welcomed by the householder because it provides freedom from insect annoyance.

"The use of DDT as a mosquito larvicide will be limited to experimental investigations and to situations where DDT has definite advantage over other larvicides in saving materials and manpower, and where it presents no hazard to fish and other wild life.

"Distribution of DDT from aircraft for large-scale area control of mosquitoes in military and adjacent areas in the United States will be limited to projects conducted with due regard

(Continued on page A8)

When patients tire of *drinking* MILK . . .

LET THEM *EAT*

MILK DESSERTS

Cool, colorful rennet-custards tempt appetites

Everything that can be said of milk can be said of rennet-custards . . . for rennet-custards *are* milk, with all its proteins, vitamins, and food minerals unimpaired by cooking!

And *what's more* . . . the rennet enzyme makes the milk more readily digestible by performing the first step in digestion. It changes milk into soft, flocculent, easily digested curds.

It's easy to make these eggless, non-cooked custards—takes but a minute. And they're so cool, delicious and delicate in texture, they solve dozens of diet and appetite problems.

RENNET-CUSTARDS

Are Widely Used in These Diets

Gastro-Intestinal	Cardiac
Post Operative	High Calcium
Convalescent	High Vitamin
Post-Tonsillectomy	Low Residue
Infants' and Children's	Pregnancy
	Nursing Mothers'
	Bland Diets

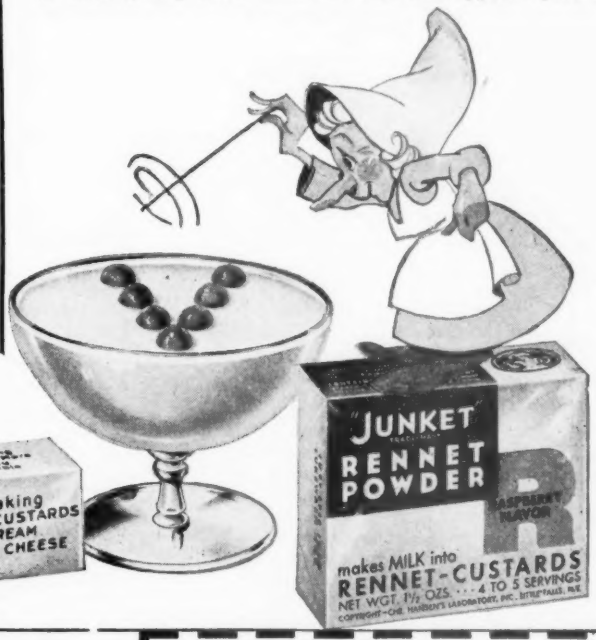
(*Send coupon for* FREE *diet list suggestions*)

Make rennet-custards with either:

"Junket" Rennet Powder—Sweetened, six delicious flavors:

Vanilla	Raspberry
Orange	Lemon
Chocolate	Maple

"Junket" Rennet Tablets—not sweetened or flavored. Add sugar or saccharine, and flavor to taste. Each rennet tablet makes 4 or 5 rennet-custard desserts. 12 tablets in package.



"JUNKET" is the trade-mark of Chr. Hansen's Laboratory, Inc., for its rennet and other food products, and is registered in the United States and Canada.

Full size sample packages . . . . . **FREE!**

diet list suggestions . . .

and helpful literature for diet planning. Diet suggestions for 16 most commonly prescribed diets.

PLEASE SEND THIS COUPON

"THE 'JUNKET' FOLKS,"
Chr. Hansen's Laboratory, Inc.
Dept. 247, Little Falls, N. Y.

Please send me without charge samples of your products, diet list suggestions and your booklet "Milk and Milk Foods in Diet Planning."

Name _____

Position _____

Address _____

City _____ State _____

Public Library
Detroit, Michigan

Copr. 1945, Chr. Hansen's Laboratory, Inc.

SAFEGUARDING BABY'S HEALTH THROUGH IMMUNIZATION

Baby Care Program for Busy Nurses

This is one of a series of chapters in a time-saving program on "Baby Care for Health and Comfort"—available *FREE* to Public Health Nurses and others engaged in conducting Mothers' Clubs. It explains the importance of immunization of pre-school children as well as babies.

The program includes seven manuals, ten illustrated wall charts . . . also a set of five small leaflets furnished in quantity for distribution to mothers. It gives instruction on bathing, dressing, rest and sleep, feeding, hygiene and immunization. Available free to you through the cooperation of:

Johnson & Johnson
The Vanta Company
The Esmond Mills, Incorporated
Gerber Products Company
Sharp & Dohme

Write to DEPARTMENT P for free set.

BUREAU of EDUCATIONAL SERVICES
a department of The Byron G. Moon Co., Inc.
401 Broadway, New York 13, N. Y.

News Notes

(Continued from page 380)

to the possible effects of DDT on beneficial insects and all forms of plant and animal life and in accordance with safeguards established by The Surgeon General of the Army and the U. S. Public Health Service."

Dr. Fred C. Bishop of the U. S. Department of Agriculture has prophesied a number of peacetime developments for DDT when it has finally been released for civilian consumption: farms with contented livestock and cleaner dairy products, outdoor areas with fewer black flies and mosquitoes, economic food production due to stricter control over insect crop destroyers—all of this in addition to better general health and happiness throughout large areas about the globe. He warns, "Much remains to be done in the perfecting of formulas for diverse uses and methods and equipment for application."

Home Canning Must Continue—The need for home canning continues to be urgent, despite the unavoidable reduction in sugar supplies. To encourage the home canning program, the U. S. Department of Agriculture and War Food Administration have sent leaders of women's organizations and youth groups a kit of home canning information materials. Even though sugar rations for canning have been cut, there is still enough left to sweeten a tremendous quantity of fruit if it is used wisely. The manufacture of 630,000 pressure canners—essential to the canning of vegetables other than tomatoes—has been authorized by the War Production Board for 1945, as compared with 400,000 last year. Tomatoes, the victory gardener's delight, take neither sugar nor pressure canner.

Incidence of Polio—The National Foundation for Infantile Paralysis (*National Foundation News*, May 1945) states " . . . it is still too early to predict with any degree of accuracy whether or not 1945 will again find our nation confronted by a serious infantile paralysis epidemic . . . " The latest figures put out by the USPHS covering reports received through the week ending May 19, 1945, show 43 states and the District of Columbia reporting one or more cases of poliomyelitis, a total of 723 as compared with 490 for this period last year:

Alabama, 33 cases; Arizona, 4; Arkansas, 6; California, 52; Colorado, 6; Connecticut, 5; Delaware, none; District of Columbia, 1; Florida, 18; Georgia, 11; Idaho, 1; Illinois, 19; Indiana, 10; Iowa, 3; Kansas, 3; Kentucky, 13; Louisiana, 8; Maine, 8; Maryland, 6; Massachusetts, 14; Michigan, 9; Minnesota, 8; Mississippi, 18; Missouri, 17; Montana, 3; Nebraska, 3; Nevada, none; New Hampshire, none; New Jersey, 12; New Mexico, 5; New York, 147;

New 3rd Edition . . . .

CARTER'S MICROBIOLOGY AND PATHOLOGY

"Brings the nurse right up to date with the latest advancement of science."—A. J. S., R.N.

777 pages, 200 illustrations, 25 color plates. $3.50

The C. V. Mosby Company
St. Louis 3, Mo.

MEMORIAL HOSPITAL
CANCER AND ALLIED DISEASES

Memorial Hospital offers to qualified, registered nurses, Public Health Nurses, and Cadet Nurses a course in Cancer Nursing. For further information apply to Director of Nurses, 444 East 68th Street, New York 21, New York.

SIMMONS COLLEGE
SCHOOL OF NURSING

offers nine-month programs in

PUBLIC HEALTH NURSING and in HEAD NURSING

Both courses include class instruction and supervised experience. Admission for course in public health nursing in September and February, for head nursing in September.

For full information apply to

DIRECTOR, SCHOOL OF NURSING
Simmons College, Boston, Mass.

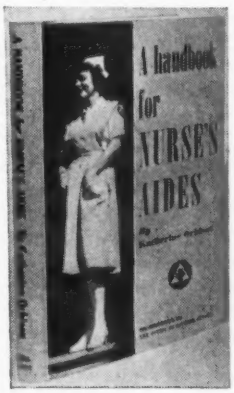
North Carolina, 23; North Dakota, 5; Ohio, 23; Oklahoma, 12; Oregon, 2; Pennsylvania, 14; Rhode Island, none; South Carolina, 14; South Dakota, 1; Tennessee, 14; Texas, 78; Utah, 5; Vermont, 3; Virginia, 16; Washington, 24; West Virginia, 6; Wisconsin, 7; Wyoming, none.

Analysis of Student Opinion of "Course Value"—A recent study at Stephens College, Missouri, to determine what the word "value" as applied to courses means to students revealed three apparent trends of student thinking with respect to courses, according to the April Stephens College *News Reporter*: (1) that most students want courses to be "practical," to give them something which they can *use* now or later (2) that most students like individual attention and respond favorably to any course procedures which tend to individualize assignments (3) that most students like a course which utilizes additional materials such as movies, slides, and field trips to supplement the regular routine of study.

REPRINTS

Preparation to Meet Psychosomatic Problems ..10c
Psychosomatic Viewpoint in Public Health Nursing ..10c
Testing Functional Ability in the Orthopedically Handicapped ..Free
Internship—Nursing Internships in Orthopedics—
Internship Plan in the Boston VNA..Free
Chronic Illness in Connecticut in 1944..10c
The Newer Occupational Diseases..5c
Part-Time Nursing Service to the Small Plant ..10c
Fifty Years of Industrial Nursing in the United States, and Industrial Nursing Begins in Vermont ..15c
Amputation Stumps and Prostheses..Free

A HANDBOOK FOR NURSE'S AIDES



by Katherine T. Orbison, R.N., M.A.

Foreword by
RUFUS COLE, M.D.
Rockefeller Institute Hospital

Introduction by
GEORGE BAEHR, M.D.
Chief Medical Officer—OCD

Every hospital procedure and technique likely to be used by Nurse's Aides clearly explained in outline form. 135 excellent line drawings further clarify the text. Primarily for Aides, this book can also be used by others as a refresher course in the most modern hospital practices. Includes section on Public Health Nursing and Care in the Home.

224 pages—4th printing—$2.00

THE DEVIN-ADAIR COMPANY
23 East 26th Street, New York 10, New York

Please send me Katherine Orbison's **A Handbook for Nurse's Aides** for 10 days' examination on approval. In 10 days I will send $2.00, plus few cents postage, or return book postpaid. (Postage paid on cash orders.)

Name .....
Position .....
Address .....
City and State .....

Public Library
Detroit, Michigan

DEPENDABILITY
in a vitamin-mineral supplement

VIMMS meet AMA recommendations
for compounding multi-vitamin formulas

AMA *Adult Minimum Daily Requirements*		VIMMS *(3 tablets)*
4,000 USP Units	A	5,000 USP Units
1 mg.	B_1	1 mg.
2 mg.	B_2 (G)	2 mg.
600 USP Units	C	600 USP Units
400 USP Units	D	500 USP Units
10 mg.	NIACIN	10 mg.

In addition, Vimms supply the minerals most commonly deficient in the average diet.

CALCIUM . . . 375 mg. • PHOSPHORUS . . . 250 mg. • IRON . . . 10 mg.

The AMA Councils on Pharmacy and Chemistry and Food and Nutrition "believe that the amounts of vitamins in mixtures should bear a relationship to the normal daily requirements. The physician then may prescribe amounts of these vitamins which would bear some simple relationship as a fraction or a multiple of the estimated daily requirements."*

CERTAIN MINERALS ESSENTIAL IN VITAMIN METABOLISM

Unlike most dietary supplements, Vimms supply not only the necessary vitamins but also the minerals which help the vitamins function most efficiently. A case in point: Calcium and Phosphorus are needed to enable Vitamins C and D to play their full role. There is also a secondary relationship between Iron and Vitamin C.

Three Vimms a day are calculated to raise the vitamin-mineral levels of the average diet up to or above the Recommended Daily Allowances of the Food and Nutrition Board of the National Research Council.**

Of the seven leading products only Vimms supplies these necessary vitamins and minerals.

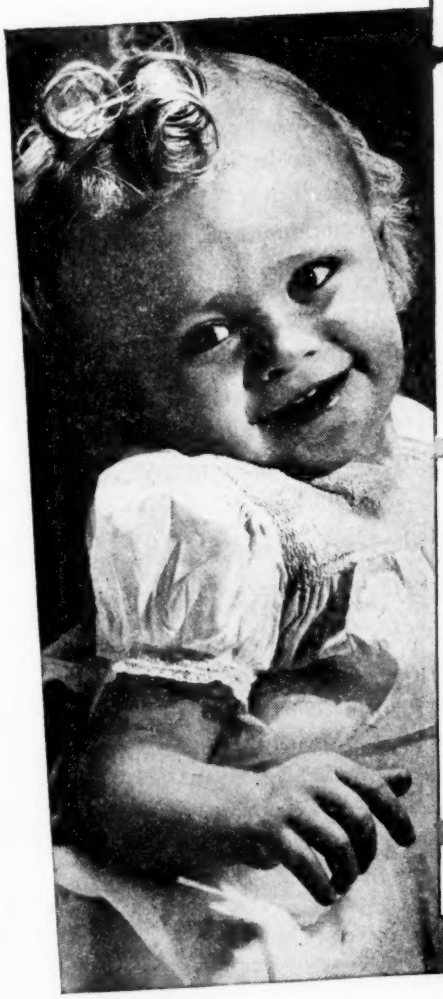
POTENCIES CONTROLLED • AVAILABILITY ASSURED • STABILITY GUARANTEED

PROFESSIONAL SUPPLIES of Vimms are available on request. Write to Pharmaceutical Division, Lever Brothers Company, Dept. PHN-09, Cambridge, Mass. (Offer good in United States only.)

*The Proper Use of Vitamins in Mixtures. Jour. of the American Medical Assoc. Vol. 119, No. 12 (July 18, 1942).

**Recommended Dietary Allowances. Nat'l Research Council Reprint and Circular Series No. 115 (Jan., 1943).

Can any infant cereal match this one?



CLAPP'S INSTANT CEREAL

Pre-cooked . . . ready to serve

Clapp's Instant Cereal is prepared from mixed cereals, fortified with vitamins and minerals, notably vitamin B_1 (thiamine) and Iron, in which the diet of infants and young children may be deficient.

INGREDIENTS

Whole Wheat Meal • Malt • Dicalcium Phosphate • Corn Meal • Dried Skim Milk • Salt • Wheat Germ • Dried Brewers' Yeast • Iron Ammonium Citrate.
1 ounce of Cereal contains not less than 100 U.S.P. units vitamin B_1 and 0.18 milligrams vitamin G.

TYPICAL ANALYSIS

Carbohydrate 71.7%	Moisture 5.7%
Protein (N x 6.25) 16.0%	Calcium (Ca) 0.34%
Fat (ether extract) 1.2%	Phosphorus (P) 0.80%
Ash (total minerals) 3.8%	Iron (Fe) 0.021%
Crude Fiber 1.6%	Copper (Cu) 0.002%
	Calories per avoir. ounce 102.

NUTRITIONAL VALUES

½-oz. and 1-oz. quantities may be considered average daily amounts for the infant and young child respectively. These amounts furnish the following percentages of the minimum daily requirements:

INSTANT CEREAL: For infants, 60% of vitamin B_1; 18% of vitamin G. For young children, 60% of vitamin B_1; 80% of Iron; 12% of Calcium; 33% of Phosphorus.

The Council on Foods and Nutrition of the A.M.A. suggests that infant cereals may well be selected upon the basis of furnishing vitamin B_1 and Iron. Clapp's Cereals are an excellent source of these two food elements and thus are preferred for inclusion in infants' diets.

CLAPP'S BABY CEREALS

CLAPP'S BABY FOOD DIVISION,
American Home Foods, Inc., Dept. E-7
22 East 40th Street, New York 16, N. Y.
Please send me a supply of professional samples of Clapp's Instant Cereal and Clapp's Instant Oatmeal.

Name_____
Address_____
City_____ State_____

Public Library
Detroit

In the Physiologic Synthesis of Biocatalytic Substances

The protein may well be called the mother-substance of life, gains substantiation from its dual role in all organic economy: it is the primary constituent of all protoplasm, and also the essential "raw-material" and component of many biocatalytic substances concerned with vital metabolic functions.

Secretin, for instance, a polydynamic substance credited with enhancing the secretion of pancreatic juice, bile, and probably also of succus entericus, is proteinic in nature, a polypeptide. Yellow enzyme, an essential factor in cellular oxidation, results from a combination of protein with riboflavin and phosphoric acid.

For the proteins and their derivatives required for such synthesis, the organism finds only one source—the proteins contained in the foods eaten.

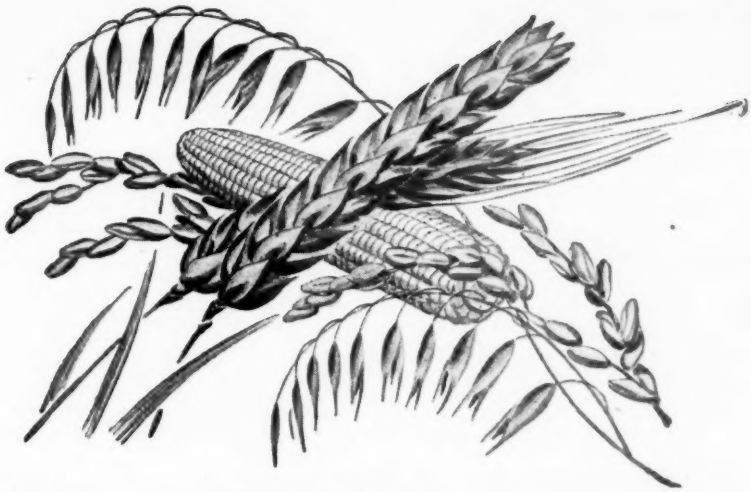
Among man's protein foods, meat ranks high, not only because of the percentage of protein contained, but principally because its protein is of highest biologic quality, applicable wherever protein is required.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED
AMERICAN MEDICAL ASSN
Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES



Women and Their Breakfasts

Women are prone to slight breakfast, whether they are engaged in business, in industry, or in the housework of their own homes. The desire to remain "stream-lined" is frequently a powerful, though misguided factor.

The fallacy of the skipped or skimped breakfast has been amply demonstrated in industry. If the interval between adequate food intake extends from the evening meal to noon of the next day, undue fatigue is apt to occur during midmorning, the acuity curve goes down, accident rates may increase. What applies in industry, applies equally to the office worker and the housewife. There is apt to be a reflection in the general state of well-being, in lessened physical and psychic competency.

The physician's advice to eat a better breakfast will go far in leading to better breakfast habits. A good start is to advise a basic breakfast of fruit, cereal (ready-to-eat or to-be-cooked) with milk and sugar, bread and butter, and a beverage. Variety in taste and form of the main dish—the cereal—makes such a breakfast acceptable and easy to eat. What this dish of 1 oz. of cereal (whole-grain, enriched, or restored to whole-grain values of thiamine, niacin, and iron), 4 oz. of milk, and 1 teaspoonful of sugar represents nutritionally, is indicated by the appended table.

Calories	**201**
Protein	**7 Gm.**
Carbohydrate	**32 Gm.**
Fat	**5 Gm.**
Thiamine	**0.19 mg.**
Riboflavin	**0.27 mg.**
Niacin	**1.82 mg.**
Calcium	**158 mg.**
Iron	**1.73 mg.**

The presence of this seal indicates that all nutritional statements in this advertisement have been found acceptable by the Council on Foods and Nutrition of the American Medical Association.

CEREAL INSTITUTE, INC.

135 SOUTH LA SALLE STREET • CHICAGO 3

For improved care of AMPUTATION and FRACTURE cases . . .

- **SEALSKIN Liquid plastic skin adhesive**

features . . . The liquid dries to form a complete coherent membrane which is very soft, highly elastic and possesses great tensile strength. Because of these qualities it affords the patient greater comfort, and a more even distribution of traction. On removal, the Sealskin adheres to the bandage and peels off as a membrane. Tests at two military hospitals have proven the advantages of this material over others previously tested.

J-500 ..... **Per 4 oz. jar $1.25**
J-502 ..... **Per 16 oz. jar $3.75**

- **HERZMARK TRACTION REEL**

features . . . There are no weights to add or take off. Any amount of traction up to twenty pounds can be set by turning the removable key. The apparatus is self-contained. It provides constant traction since the weights are not bumped into, cannot become caught in the bedding, or at the foot of the bed. Furthermore, once the traction is adjusted and the key removed, visitors cannot change the adjustment. Movement on the part of the patient causes practically no variation in the amount of traction. The apparatus is easily attached to the bed with one wing nut and two wooden horizontal cross bars. When setting up the vertical extension, two wing nuts are used. The apparatus is durably built . . . there is nothing to get out of order.

B-1000 Herzmark-Adams Traction Reel complete with two 12″ wooden horizontal bars and one 14″ vertical extension bar **$34.50**

Write for literature on your letterhead please.
Order from your surgical supply dealer.

CLAY-ADAMS CO., INC. • 44 East 23rd St., NEW YORK 10, N. Y.

Warner's
CHAFEZE*

The original soft jersey shield that prevents painful chafing. It is of particular comfort in hot weather and launders like lingerie. Sold ONLY in Corset Departments.

Ask for it by name
CHAFEZE*. $1.25 and $1.50

*Reg. U. S. Pat. Off.

THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY OF THE UNIVERSITY OF CHICAGO

offers to qualified nurses the following courses:

(1) Four months—Basic course for those who wish broader experience in Obstetric Nursing. This course includes experience in hospital and dispensary services. Full maintenance is provided.

(2) Four months—Advanced course for those who wish to prepare for positions of responsibility in Institutional or Community Obstetric Services. Open to registered nurses who have had experience or advanced study in institutional or public health nursing. Charge made for part of maintenance cost.

The Gussie DeLee scholarship of $100 available each year for this course. The Nursing Education Department of the University of Chicago will grant credit to students who satisfactorily complete the advanced course and who meet the admission requirements of the department.

For further information apply to
DIRECTOR OF NURSING
5841 Maryland Avenue Chicago 37, Illinois

WANTED—Registered nurses for Hospital, clinic, or district; with scholarships in Frontier Graduate School of Midwifery, available to nurses on staff who qualify. Six weeks' vacation a year with full pay. Please give age and experience in first letter. For details apply: **Assistant Director, FRONTIER NURSING SERVICE, Wendover, Kentucky.**

WANTED

Science Instructor and Instructor for Public Health and allied subjects, salary $163.00, full maintenance. Clinical Instructor, evening duty, $173.50 plus laundry and meals. Cadet Corps Program, New Education Building. Apply Jackson Memorial Hospital, Miami, Florida.

WANTED—Graduate Staff Nurses; Operating Room Nurses. Apply Memorial Hospital, 444 East 68th Street, New York 21, New York.

For Irritated Skin Use a Medicated Soap That Is...

- ECONOMICAL
- FRAGRANT
- GENTLE
- MILD

So pure and fine, so free from excess alkali, Cuticura Soap may be used with safety even on a new-born baby. In addition, it is emollient, mildly medicated, luxuriously fragrant and long-lasting. For relief of externally caused pimples, rash and other irritations, use with Cuticura Ointment. FREE samples to nurses. Write Cuticura, Dept. PH1, Malden, Mass.

Mildly Medicated

CUTICURA SOAP

GEORGE PEABODY COLLEGE FOR TEACHERS

Public Health Nursing

Certificate and Degrees

Professional Preparation in Health and Nursing Education for School, Rural, and Urban Public Health work, including field experience. Educational phases of the work are emphasized.

SUMMER QUARTER
Registration Days—June 11, 12

FALL QUARTER
Registration Day—September 24

For Information and Bulletin address
Division of Nursing Education

GEORGE PEABODY COLLEGE FOR TEACHERS
Nashville 4 Tennessee

NURSE PLACEMENT SERVICE

(Approved Bureau of NOPHN)
8 South Michigan Blvd., Chicago 3, Illinois
ANNA L. TITTMAN, R.N., *Executive Director*

ADMINISTRATION: *Director of Nursing:* Large Eastern city official health department; excellent administration; university PHN student affiliation. No. 45-1024.

EDUCATION: *Instructor PHN:* Increasing number calls for teaching in basic nursing program for fall appointment.

CONSULTATION: *Nursing Consultants:* Generalized —State or area basis; various parts USA; private and official; also specialized; orthopedic, maternity, tuberculosis. *Orthopedic Consultant:* Large Southern City Dept. Health, special preparation required; $180, increase to $210. No. 45-1018. Similar position Midwest State Crippled Children's Commission; $210-$250. No. 45-1019.

RESEARCH WORKER: To conduct studies in Tuberculosis patient survival, incidence in relief families, etc.; involves working with other agencies; large Eastern City Tuberculosis Assoc. $2600-$2800. No. 45-1017.

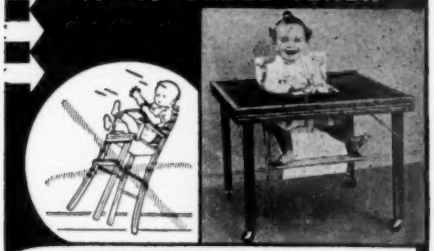
SUPERVISION: *Supervisor:* (a) Large Eastern City VN Society; well administered; PHN university student affiliation; also undergraduate; $2900-$3300. No. 44-3105. (b) County Dept. Health; teaching center; university affiliation; Mountain Area; $210 plus 7 cent car mileage. No. 45-0402. (c) Asst. Supervisor same as (b) but with headquarters in another city and with maternity demonstration except delivery service; $181.50 plus maximum $60 travel budget. No. 45-0871. (d) Many others.

SCHOOL: Public Schools for fall appointment—one-nurse and staff openings; latter under excellent supervision.

STAFF: Urgent needs urban and rural; official rural; require PHN certificate for salaries of $175-$200.

Write for Application—No Registration Fee.

Tell New and Expectant Mothers *about* BABEE-TENDA



The NEW Safety Chair that PROTECTS Baby from SERIOUS FALLS

PAT. NO. 2161658

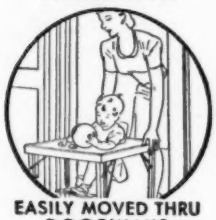
Thousands of Doctors and Public Health Nurses recommend the BABEE-TENDA Safety Chair because they know from actual experience that falls from high chairs can be serious and fatal to Baby. BABEE-TENDA cannot be pulled or tipped over because it is low and square, 22" high and 25" square. A Safety Halter Strap positively prevents Baby from climbing out and mother can go about her work without fear for Baby's safety. The BABEE-TENDA Safety Chair is the first revolutionary improvement since the high chair. Very highly recommended by Baby Specialists because it protects Baby from SERIOUS FALLS. Specialists say that Baby should not be fed at the family table — there are too many distractions that lead to emotional upsets and result in bad feeding habits. Use the BABEE-TENDA Safety Chair to develop proper feeding habits. Recommend to mothers for Babies at sitting up age.

Copyright 1945 by The Babee-Tenda Corp'n

Some of BABEE-TENDA advantages over high chairs

FEEDING AT FAMILY TABLE

OUT OF THE WAY UNDER TABLE



EASILY MOVED THRU DOORWAYS

EASILY CHANGED TO PLAY TABLE

NOT SOLD IN STORES

SOLD ONLY DIRECT TO CONSUMER . . . THROUGH AUTHORIZED AGENTS. WRITE FOR FREE INSTRUCTIVE FOLDERS AND NAME OF NEAREST AGENT.

THE BABEE-TENDA CORPORATION
750 Prospect Ave., Dept. PN Cleveland 15, Ohio

They Practice What You Preach

Teaching each new crop of mothers how to be *good* mothers is a big job. Wherever groups of new mothers get together at Maternity Centers or at clinics, you will find that the hardest work is done by

The CHASE BABY

For a quarter century it has been the recognized standard equipment for demonstrating every detail in the care of children from bathing and dressing to teaching the technique of giving douches and enemata. The Chase Baby lets your pupils practice in the clinic what you teach them.

Several different models, all life-size, waterproofed and built for years of hard wear.

For complete information write to

M. J. CHASE
24 Park Place - - Pawtucket, R. I.

Wyeth

REG. U. S. PAT. OFF.

"Sure My Eyes Are Bright—

they've just had their 3-drop shower!"

NOBODY knows better than a nurse that eyes need to be refreshed . . . cleansed of foreign particles, soothed after strain due to work, glare, wind.

That's why you should treat your eyes to that refreshing new "3-drop shower"—3 cleansing drops of Collyrium Soothing Eye Drops in each eye!

Collyrium Soothing Eye Drops contain ephedrine. They are isotonic with the tears. Supplied in bottles of 5 fluidrams with eye dropper.

You may prefer Collyrium Soothing Eye Lotion (without ephedrine) in 4- and 7-fluidounce bottles with handy attached eye-cup.

COLLYRIUM

SOOTHES, CLEANS EYES

WYETH INCORPORATED
PHILADELPHIA 3, PENNA.

WYETH INCORPORATED
1600 ARCH STREET, PHILADELPHIA 3, PA.

Will you send me Collyrium Wyeth for my use, as marked; I would prefer:

☐ COLLYRIUM Soothing Eye Drops ☐ COLLYRIUM Soothing Eye Lotion

*Name*_____

*Address*_____

*City*_____ *Zone*_____ *State*_____

Public Library
Detroit, Michigan

Press of Thomas J. Griffiths Sons, Inc., Utica, N. Y.

BECAUSE THEY SERVE

In this holocaust of destruction which is our gloomy life today, some of the brightest rays of happiness stem from the work and sacrifice of the nursing profession. ¶ From the military fronts come heroic tales of miracles of technical nursing care . . . and the less definable miracles which lie in the sustenance of smiling faith, courage and hope in our wounded fighting men . . . miracles which come to pass despite the depressing burdens of streams of ghastly casualties, despite the fatigue of life in mud and filth and danger, despite the personal concerns and disturbing anxiety for loved ones, too little sleep and too few helping hands and all of the fury and terror and hopelessness of battlefield service. ¶ From the civilian fronts, too, for those who can hear, come tales of nursing service of equal . . . if perhaps, less dramatic . . . importance. And not the least of these is the yet to be told story of the work and devotion to duty and sacrifice and achievements of the public health nurse. Understaffed even in the best peacetime years, the decimated ranks of public health nurses have stood as a bulwark against the rising flood tide of illness and disease which is the natural result of a wartime era. Here at home, they have protected that core of the world which, to each of our fighting men is the essence of his reason for fighting. ¶ Yes, today as always, on home and military front alike, service by the nursing profession yields happiness and joy where the gloom of misery would abide.

BRUCK'S IS PROUD TO SALUTE THE NURSING PROFESSION!

Bruck's is proud, too, of its own record of quiet achievement. Through careful planning and a minimum number of models, Bruck's has been able to supply sturdy, dependable public health apparel to its customers despite labor and material shortages, unprecedented demand, and dislocations of wartime production.

★ BRUCK'S ★
NURSES OUTFITTING COMPANY, INC.
387 Fourth Ave., New York ★ 17 N. State St., Chicago